(28) (84)

Nos. 84-325 and 84-356

FILED
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CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

On Appeals from the Supreme Judicial Court for the Commonwealth of Massachusetts

---

JOINT APPENDIX

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APPEALS DOCKETED AUGUST 30, 1984
PROBABLE JURISDICTION NOTED OCTOBER 29, 1984

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SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT
FOR CIVIL BUSINESS
SUFFOLK, SS.

Docket No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFFS

vs.

THE TRAVELERS INSURANCE COMPANY, AND ANOTHER,
DEFENDANTS

METROPOLITAN LIFE INSURANCE COMPANY

Action #35 Injunction,
#45 Declaratory Judgment and
#47 Consumer Protection

Plaintiff's Counsel

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Arthur Leavens
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New York, New York 10154
Tel. (212) 644-8000

DOCKET ENTRIES

Date	No.	Entered
1979		
June 1	1	Complaint. Notice ordered issued re: prayer 2 returnable Tuesday, June 26, 1979. Adams, J. (2) Summonses and orders of notice issued.
June 1	—	Civil action cover sheet re: Complaint mailed.
June 15	2	Civil action cover sheet re: Complaint.
June 21	3	Stipulation to enlarge time for defendants to file Answer to and including July 17, 1979.
July 18	4	ANSWER of defendants.
July 23	5	Affidavit of Brooks Joslin.
July 23	6	Affidavit of Jack B. Helitzer, Assistant Vice President of Metropolitan Life Insurance Company.
Aug. 13	7	Memorandum of Decision. Mitchell, J.
Aug. 28	8	ORDER: It is Ordered, Adjudged and Decreed: that upon payment to the Clerk of the sum of $5.00 the application for preliminary injunction is hereby granted. Mitchell, J. Notice sent 8/29/79.

Date	No.	Entered
1979		
Oct. 15	9	Motion of defendant to assign new trial date from November 1979 to January 15-16, 1980.
Oct. 25	—	Motion (P#9) allowed. Lynch, Jr., C.J.
Oct. 25	10	Order: Ordered that action be placed on the without jury list for hearing in the advanced section during the week of January 14, 1980 re: merits. Lynch, Jr., C.J. Notice sent.
1980		
Mar. 21	11	ORDERED: that action be placed on the without jury list for hearing in the advanced section week of June 9, 1980—first case out—in re: merits. Lynch, Jr., C.J. Notice sent 3/24/80.
June 6	12	Joint motion to continue action from June 9, 1980 to July 28, 1980, and allowed. Meyer, J.
July 10	13	Joint motion to continue action to September 22, 1980, and allowed. Meyer, J.
Sept. 22	—	Trial 2nd Session without jury at Cambridge, Brady, J.
Sept. 24	13A	Stipulation, filed by leave. Brady, J.
Sept. 25	13B	Stipulation, filed by leave. Brady, J.
Sept. 25	13C	Supplemental stipulation, filed by leave. Brady, J.
Sept. 29	13D	Second supplemental stipulation, filed by leave. Brady, J.
Oct. 17	14	FINDINGS AND CONCLUSIONS PURSUANT TO MASS. R. CIV. P. 52. Brady, J. Notice sent 10/22/80.

Date	No.	Entered
1980		
Oct. 22	15	JUDGMENT ON FINDINGS BY THE COURT, and approved, Brady, J., entered on Docket pursuant to Mass. R. Civ. P. 58(a) and notice sent to Mass. R. Civ. P. 77(d).
Nov. 14	16	Motion of defendants for temporary relief from Judgment, assented to and allowed. Brady, J.
Nov. 14	—	Motion (P#16) allowed. Brady, J.
Nov. 17	17	Motion of defendant for a stay pending appeal.
Nov. 17	18	Affidavit of Jack B. Helitzer.
Nov. 19	—	Motion (P#17) allowed to stay to November 25, 1980 only, the date of hearing of Commonwealth's motion to amend judgment. Brady, J.
Nov. 19	18A	Points and Authorities in opposition to motion to stay.
Nov. 25	—	Motion (P#17) denied. Brady, J.
Nov. 25	18B	Motion of plaintiff to amend or modify judgment.
Nov. 25	18C	Affidavit of David Schwartz.
Dec. 1	19	JUDGMENT ON FINDINGS BY THE COURT for plaintiff vs. defendants and approved. Brady, J., entered on Docket pursuant to Mass. R. Civ. P. 58(a) and notice sent to parties pursuant to Mass. R. Civ. P. 77(d).
Dec. 3	20	Notice of appeal of defendant The Travelers Insurance Company.
Dec. 3	21	Notice of appeal of defendant Metropolitan Life Insurance Company.

Date	No.	Entered
1980		
Dec. 8	—	Notice to Justice Peter F. Brady of the filing of a notice of appeal.
Dec. 8	—	Notice of service of notice of appeal to Francis X. Bellotti, Attorney General, Sally A. Kelly, Assistant Attorney General, Arthur Leavens, Esquire, and Earle Doppelt, Esquire.
1981		
Apr. 30	22	Transcript of Testimony. (5 Volumes).
May 1	23	Defendants' motion to file annexed certification of transcript and to enlarge time for assembly of record on appeal until May 8, 1981, and allowed. Furnari, J.
May 5	—	Notice of assembly of record on appeal.

COPY,

ATTEST:

/s/ [Illegible]
Assistant Clerk

SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT

COMMONWEALTH OF MASSACHUSETTS
SUFFOLK, SS

No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

vs.

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Jun. 1, 1979]

COMPLAINT

I. STATEMENT OF THE CASE

1. This action is brought by the Attorney General of the Commonwealth of Massachusetts for declaratory and injunctive relief. The Attorney General seeks to restrain the defendant insurance companies from failing to provide coverage and benefits for treatment of mental and nervous conditions to Massachusetts subscribers of group insurance policies issued by the defendants where such benefits are mandated by G.L. c. 175, § 47B.

II. JURISDICTION

2. Jurisdiction is conferred on the Court by G.L. c. 93A, §4, G.L. c. 12, § 10, G.L. c. 231A, § 1, and G.L. c. 214, § 1.

3. The plaintiff has sent and the defendants have each received a notice, pursuant to G.L. c. 93A, § 4, of the intention of the Attorney General to file suit to enforce the provisions of G.L. c. 175, § 47B.

III. PARTIES

4. The Commonwealth of Massachusetts is a sovereign state of the United States represented by the Attorney General.

5. The Travelers Insurance Company is a corporation duly organized and existing under the laws of the State of Connecticut, with a principal address at One Tower Square, Hartford, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

6. Metropolitan Life Insurance Company is a corporation duly organized and existing under the laws of the State of New York, with a principal address at One Madison Avenue, New York, New York, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

IV. FACTS

7. At all times relevant hereto, the defendant insurance companies have been authorized by the Commissioner of Insurance, pursuant to G.L. c. 175, § 150, to engage in the business of insurance in the Commonwealth. *See* attached Exhibits A and B. The defendants each engage in the business of insurance in the other states of the United States.

8. In the course of its business, each of the defendant insurance companies issues group insurance policies to policyholders which provide hospital and surgical expense for subscribers of the group insurance policies who are residents of the Commonwealth.

9. As used herein, the term "policyholder" generally refers to an employer or employee organization which

provides medical care benefits to employees ("subscribers") through the purchase of group insurance. Such policyholders may qualify as "employee welfare benefit plans" as defined by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1002(1).

10. G.L. c. 175, § 47B was enacted on December 10, 1973, effective January 1, 1976, and provides, in part, as follows:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, . . . [shall] provide benefits for expense of residents of the Commonwealth covered under any such policy or plan, arising from mental or nervous conditions . . . which are at least equal to the following minimum requirement:
>
> . . . (c) In the case of outpatients benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital, (3) or subject to the approval of the department of mental health services furnished by a community mental health center . . . which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under provisions of chapter one hundred and twelve.

11. The defendant insurance companies have issued numerous group insurance policies since January 1, 1976 to policyholders situated outside the Commonwealth

which provide benefits for hospital and surgical expense to subscribers who are residents of the Commonwealth. In each such instance, the defendants have failed to provide Massachusetts resident subscribers the coverage and benefits for mental and nervous conditions mandated by G.L. c. 175 § 47B. *See* Affidavits of Donald Becker, Esquire and Carolyn LaMare attached hereto as Exhibits C and D.

12. The defendant insurance companies have offered to issue group insurance to prospective policyholders outside the Commonwealth which will provide benefits for Massachusetts resident subscribers. The defendants have represented to prospective policyholders that the benefits mandated by G.L. c. 175 § 47B are not required on policies issued outside of the Commonwealth.

13. The defendant insurance companies issued numerous group insurance policies, effective prior to January 1, 1976, which contain no traditional "renewal" clause among the policy terms. However, the defendants retain the right to increase premiums on each such policy. In addition, the defendants and their policyholders may alter other policy terms and benefits by agreement. Such policies have been issued both within and outside the Commonwealth providing coverage to Massachusetts resident subscribers. *See* Affidavit of Donald Becker, Esquire attached hereto as Exhibit C.

14. On information and belief, the defendants have since January 1, 1976 increased the premiums, or altered the policy terms, or both, by agreement with the policyholders of many of the policies described in paragraph 13. The payment and receipt of increased premiums, or alteration of policy terms and benefits constitutes the issuance of a new policy or, alteratively [*sic*], the renewal of the original policy.

15. Where group insurance policies issued by the defendant insurance companies have been renewed or re-

issued since January 1, 1976 through the payment of increased or renewal premiums, or the alteration of policy benefits, the defendants have failed in each such instance to provide to subscribers who are residents of the Commonwealth the coverage and benefits for mental and nervous conditions mandated by G.L. c. 175 § 47B.

16. The defendant insurance companies have denied coverage and benefits mandated by G.L. c. 175 § 47B to Massachusetts residents subscribers of group insurance policies issued by them on various grounds, including:

(a) the policy contains no provision for renewal, and is subject to continuation at the option of the policyholder, and therefore is not subject to § 47;

(b) the policy is issued to a qualified employee welfare benefit plan and, therefore, state law is preempted by ERISA;

(c) § 47B may not be applied extraterritorially to a policy issued outside of Massachusetts. The application of § 47B to a policy issued outside of Massachusetts violates the U.S. Constitution;

(d) where the application of § 47 would have the effect of altering benefits subject to collective bargaining, it is preempted by the National Labor Relations Act. *See* Affidavits of Donald Becker, Esquire and Carolyn LaMare attached hereto as Exhibits C and D.

V. IRREPARABLE INJURY

17. As a result of the failure by the defendants to comply with G.L. c. 175, § 47B, many residents of the Commonwealth have been deterred from obtaining treatment, or have been forced to discontinue treatment for mental and nervous conditions.

VI. CAUSE OF ACTION

18. The defendants have violated G.L. c. 175, §§ 3 and 47B, and G.L. c. 93A, § 2(a) by their failure to provide coverage and benefits for expense of treatment for mental or nervous conditions for residents of the Commonwealth who are subscribers of group insurance policies issued by the defendants.

VII. RELIEF

WHEREFORE, the plaintiff requests that this Honorable Court:

1. Issue an Order of Notice.

2. After return of the order of notice, issue a preliminary injunction restraining the defendants from the failure to provide benefits for expense for treatment of mental or nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976.

3. After a hearing on the merits, determine that the defendants have failed to comply with G.1. c. 175, § 47B, and that such failure is a violation of G.L. c. 93A, § 2(a) and G.L. c. 175, § 3.

4. After hearing on the merits, issue a permanent injunction in accordance with prayer 2, and further:

(a) restrain the defendants from failure to provide benefits for expense for treatment of mental or nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies issued by the defendant prior to the effective date of § 47, but which have been reissued or renewed by an increase in premium, or alteration of policy benefits since January 1, 1976.

(b) order that the defendants shall provide notice of the benefits provided by G.L. c. 175, § 47B to each Massachusetts subscriber whose policy is altered by the judgment of the Court in this case.

5. Award the Commonwealth its reasonable costs and attorney's fees.

6. Award such other and further relief as the Court deems just.

COMMONWEALTH OF MASSACHUSETTS
FRANCIS X. BELLOTTI
ATTORNEY GENERAL

BY: /s/ John T. Montgomery
JOHN T. MONTGOMERY
Chief
Insurance Division
Public Protection Bureau
One Ashburton Place
Boston Massachusetts 02108
(617) 727-8048

BY: /s/ Sally A. Kelly
SALLY A. KELLY
Assistant Attorney General
Consumer Products Division
Public Protection Bureau
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-8191

EXHIBIT A

[SEAL]

THE COMMONWEALTH OF MASSACHUSETTS
Division of Insurance
100 Cambridge Street, Boston 02202

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT

THE TRAVELERS INSURANCE COMPANY
HARTFORD CONNECTICUT

having complied with the requirements of the laws of this Commonwealth relating to insurance companies, as prescribed by Chapter 175 of the General Laws, was licensed by this Department to transact the business of insurance on July 23, 1864

and has been licensed from that date to the present time.

IT IS FURTHER CERTIFIED THAT the current license, having been issued on July 1, 1978 will expire on June 30, 1979 unless suspended or revoked by this Department prior thereto.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Division at the City of Boston this tenth day May A.D. 1979.

/s/ M.J. Sabbagh
M.J. SABBAGH
Commissioner of Insurance

(The above certificate is issued pursuant to Section 16 of Chapter 175 which prescribes such certificate shall be received by the Courts in lieu of the testimony of the Commissioner.)

EXHIBIT B

[SEAL]

THE COMMONWEALTH OF MASSACHUSETTS
Division of Insurance
100 Cambridge Street, Boston 02202

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK NEW YORK

having complied with the requirements of the laws of this Commonwealth relating to insurance companies, as prescribed by Chapter 175 of the General Laws, was licensed by this Department to transact the business of insurance on November 15, 1866

and has been licensed from that date to the present time.

IT IS FURTHER CERTIFIED THAT the current license, having been issued on July 1, 1978 will expire on June 30, 1979 unless suspended or revoked by this Department prior thereto.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Division at the City of Boston this tenth day of May A.D. 1979.

/s/ M.J. Sabbagh
M.J. SABBAGH
Commissioner of Insurance

(The above certificate is issued pursuant to Section 16 of Chapter 175 which prescribes such certificate shall be received by the Courts in lieu of the testimony of the Commissioner.)

EXHIBIT C

AFFIDAVIT OF DONALD L. BECKER, ATTORNEY FOR DIVISION OF INSURANCE

I, Donald L. Becker, hereby depose and say as follows:

1. I am an attorney on the legal staff of the Massachusetts Division of Insurance, and have worked in that capacity since March, 1977.

2. Throughout the period of my employment with the Division, I have been responsible for enforcing compliance by insurers with Chapter 1174 of the Acts of 1973, which was codified into Chapter 175, Section 47B, Chapter 176A, Section 8A, and Chapter 176B, Section 4A.

3. Chapter 1174 of the Acts of 1973 provides for the inclusion of specified coverages for the treatment of mental illness in health insurance policies, employees health and welfare funds, hospital service contracts, and medical service contracts. On January 1, 1976, the provisions of Chapter 1174 became mandatory on all insurers providing health insurance coverage for Massachusetts residents regardless of whether the policy was issued within or without the Commonwealth.

4. Since 1976, the Division has received numerous complaints from Massachusetts residents alleging noncompliance with the provisions of Chapter 1174 on group insurance policies. Most of these complaints have been against the defendants, Travelers Insurance Company and Metropolitan Life Insurance Company. Letters of denial of coverage have generally stated that the policy in question only provides coverage for treatment by a duly qualified physician, or that because the policy was issued in another state, Chapter 1174 does not apply. Examples are attached hereto as Exhibit C(1).

5. The Division has endeavored to secure compliance with Chapter 1174 through meetings and correspondence with representatives of the defendant-insurers. The defendant-insurers have continued to refuse compliance on the basis of various contentions, including the following: (1) that Massachusetts cannot mandate benefits to be included in policies written in other states, (2) that the Federal Employee Retirement Income Security Act of 1974 denies Massachusetts the right to regulate an employer's employee benefit plan, and (3) that the National Labor Relations Act denies Massachusetts the right to interfere with benefits agreed to pursuant to collective bargaining. Examples of correspondence from the defendant-insurers setting forth these arguments are attached hereto as Exhibit C(2).

6. The Division, after reviewing the complaints against the defendant-insurers alleging noncompliance with Chapter 1174, considered regulatory action to secure enforcement of the statute. However, the Division questioned the appropriateness of the use of its regulatory authority in this situation, particularly in view of the complexity of the issues that would inevitably have to be litigated. Consequently, the Division decided that the best course of action was to defer to litigation to be brought by the Department of the Attorney General in order to obtain a definitive judicial determination of the issue.

7. Judicial review and determination of the issues involved in this matter is essential in order to clarify the rights of Massachusetts residents to the mental health benefits mandated to be provided to them by the terms of Chapter 1174.

8. Both Travelers and Metropolitan derive substantial revenue in Massachusetts from group insurance policies which provide coverage to residents of the Commonwealth. *See* exerpts from the 1978 Annual Statements

filed by each company with the Division of Insurance, and attached hereto as Exhibits C(3) and A(4).

Signed under the PAINS and PENALTIES of PERJURY this 30th day of May, 1979.

/s/ Donald L. Becker
DONALD L. BECKER

EXHIBIT C(1)(a)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

August 8, 1978

North Shore Guidance Center
162 Federal Street
Salem, Ma. 01970
Attention: Leona Pelletier
Insurance Secretary

Subject: GTE Sylvania, Inc.
Group Policy: GA463000AA
Re: Group Health Claim

Dear Ms. Pelletier:

I have received your letter dated June 26, 1978, in regard to services rendered on March 16, 1977 to . In addition, I note your references to Massachusetts General Laws, Chapter 1174.

The subject contract with GTE Sylvania was issued in the State of Delaware and not in the Commonwealth of Massachusetts and, therefore, Chapter 1174 is not applicable.

If you have any further questions, please feel free to contact me.

Sincerely yours,

/s/ Daniel W. Jordan
DANIEL W. JORDAN
Assistant Manager

DWJ:amc

EXHIBIT C(1)(b)

[SEAL]

THE TRAVELERS

December 21, 1976

Group Claim Department
C. J. Keller, Manager
Mary Pederson
Dudley, Mass.

For: Mary
File Number: 493 HS 97398
Policyholder: Curlin Matheson

Dear Miss Pederson:

We have received a statement from William J. Rafferty, Phd. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Charlene Strok
CHARLENE STROK
Group Claim Processor

CS/dr

CC: Carlin Matheson
110 Commerce Way
Woburn, Mass.

EXHIBIT C(1)(c)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

December 20, 1976

A Y
—— Commonwealth Ave.
Boston, Massachusetts

For: E
File Number:
Policyholder: Boston Globe

Dear Mr. Y

We have received a statement from Hyman L. Kempler, Phd. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Charlene Strok
CHARLENE STROK
Group Claim Processor

CS/dr

CC: Boston Globe
135 Morrissey Blvd.
Dorchester, Mass.

EXHIBIT C(1)(d)

[SEAL]

THE TRAVELERS
Group Claim Department
C. J. Keller, Manager

January 26, 1977

Chelmsford, Mass. 01824

GTE Sylvania, Inc.
Group Policy Contract GA-463000 AA
Claim No.:
Re:

Group Health Claim

Dear Mr.

We have carefully investigated your claim to see if there was some basis for payment. However, we find it does not meet policy requirements in the sense that the services are not considered "medical care and treatment" for an accidental bodily injury or sickness.

The Group Policy, issued in the State of Delaware, provides coverage for the expense for the performance of out-patient "medical care and treatment" by a physician. While the term "physician" is not limited to a doctor of medicine, it does not include those whose services do not fall with the category of "medical care and treatment" outlined in the policy.

The question has been raised whether this policy is required under the Massachusetts Mental Health Law to cover the type of services provided by Peter Wish, Phd. That law is applicable, upon renewal, to Group Policies issued within or without Massachusetts. This policy is not subject to renewal but is automatically continued so long as the employer continues to pay the premiums. As your employer has not elected to include these statutory

benefits in the policy, we are not in the position to amend unilaterally the Group Policy and charge your claim to the experience of the policyholder. Under the Employee Retirement Income Security Act of 1974, it is questionable whether the Employee Benefit Plan for GTE Sylvania can be required by state statute to provide benefits, or in any other way to regulate the plan.

Should you have any question in this regard, please do not hesitate to contact us.

Very truly yours,

/s/ Charles J. Keller
CHARLES J. KELLER
Manager

CJK:tf

EXHIBIT C(1)(e)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

Needham, MA 02192

March 25, 1977

For:
File Number: 493 HS 19034
Policyholder: GTE Laboratories

Dear Mr.

We have received a statement from Sandra Aizley, M.S.W. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Daniel W. Jordan
DANIEL W. JORDAN
Assistant Manager

DJ/pr

EXHIBIT C(1)(f)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

July 15, 1977

For
File Number: 493 HS 36150
Policyholder: Fenwal Inc.

Dear

We have received a statement from Ethan Pollack, Ph.D. for services rendered.

We regret thatwe are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ M. Lepage
MINDA LEPAGE
Group Claim Processor

CC: Fenwal Inc.
400 Main St.
Ashland, Ma.

ML/dr

EXHIBIT C(1)(g)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

Ocotber 13, 1977

Framingham, Mass.

For:
File Number: 493 HS 41998
Policyholder: GTE Sylvania

Dear Mr.

We have received a statement from Bea Dube, Ph.D. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Kathleen Farrar
KATHLEEN FARRAR
Group Claims Processor

KF/jp

EXHIBIT C(2) (a)

METROPOLITAN LIFE
One Madison Avenue
New York, N.Y. 10010

George L. White
Vice-President
Government and Industry Relations

Joseph Ciccio, Esq.
Deputy Commissioner
The Commonwealth of Massachusetts
Division of Insurance
100 Cambridge Street
Boston, Massachusetts 22202

Re

Employer: Monsanto
Group No.: 11100-G

Dear Mr. Ciccio

Chief Examiner Moynihan of the Springfield Office asked that I contact you concerning the above case, involving the applicability of Section 47B of Chapter 175 of the Annotated Laws of Massachusetts.

Services were rendered to Mr. Vickers' daughter, Lauri, by a psychologist, Dr. Sidney Hyman on referral from Boston Children's Hospital. Because services rendered by psychologists are not covered under the provisions of the policy issued by Metropolitan to the Monsanto Company, Mr. Vickers' claim was denied. For the reasons referred to hereinafter, we believe that the denial was proper and that Section 47B is not applicable to the policy issued by Metropolitan to the Monsanto Company in Missouri.

Section 47B of Chapter 175 was enacted by the General Court in 1973 and became effective January 1, 1974.

Essentially, it required insurers to offer benefits for coverage of mental illness under certain circumstances. Effective January 1, 1976, such benefits became mandatory. As relevant to the present situation, Section 47B provides:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective . . . shall . . . provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:
>
> (c) In the case of outpatient benefits these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve.

Dr. Hyman is licensed under the provisions of chapter one hundred and twelve.

Section 47B of Chapter 175 is applicable to certain group policies ". . . described in subdivision (A), (C), or (D) of section one hundred and ten which . . . (are) issued

or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth . . ." In our view, Subdivisions (A), (C) and (D) of Section 110 apply only to policies delivered in the Commonwealth. Accordingly, Section 47B should be read to apply only to policies initially issued in Massachusetts which are subsequently renewed, within or without the State.

Also, as pointed out in prior correspondence on this matter, Group Policy No. 11100-G, issued by Metropolitan to the Monsanto Company in Missouri in 1946, does not give Metropolitan the right to non-renew, other than for non-payment of premium. As you may know, it was recently held by the New York Court of Appeals in *HIAA v. Harnett*, a copy of which is attached, that laws made applicable on a policy's renewal cannot be applied to existing policies under which the insurer does not have the right to non-renew. Moreover, the Monsanto policy is not renewed by agreement between Metropolitan and Monsanto. Metropolitan has no choice but to renew the policy; Monsanto continues the existing policy in force by merely continuing to pay the required premiums. For this reason, too, we firmly believe that Section 47B is not applicable to Group Policy 11100-G.

Also, Group Policy 11100-G reflects the results of collective bargaining agreements between Monsanto and the unions representing its employees. Under federal labor policy, statutes like Section 47B cannot alter these negotiated benefits. Additionally, it should be noted that the Monsanto policy is on an excess risk basis under which benefit payments become the liability of the insurance company only when claims exceed a specified trigger point. Then, too, serious constitutional questions arise if the statute is applied extraterritorially to the Monsanto policy which was delivered in Missouri. If the insurance departments attempt to apply these type laws extraterritorially, the resulting balkanization of group insurance

will so increase the cost of administration as to eliminate the very economies which have enabled group insurance to provide low cost coverage for an ever-increasing segment of the population. It will also have the undesirable effect of forcing employers to establish fully self-insured arrangements.

We would be happy to discuss the matter further, should you deem it to be appropriate.

Very truly yours

/s/ G. L. White
Vice-President

July 25, 1978

GLW:11

Attachment

EXHIBIT C(2)(b)

METROPOLITAN LIFE INSURANCE COMPANY

One Madison Avenue
New York, N.Y. 10010

George L. White
Vice-President
Government and Industry Relations

The Honorable James M. Stone
Commissioner of Insurance
The Commonwealth of Massachusetts
Division of Insurance
100 Cambridge Street
Boston, Massachusetts 02202

Attention: Mr. John Petropoulos
Insurance Examiner
Consumer Service Section

Re Family Counseling and Guidance Centers

Dear Commissioner Stone

This will supplement Mr. Morrison's letters of May 16 and July 18, 1978.

We are, of course, aware of the requirements of Chapter 1174 of the laws of 1973, which enacted Section 47B of Chapter 175 of the Annotated Laws. Essentially, it required insurers to offer benefits for coverage of mental illness under certain circumstances. Effective January 1, 1976, such benefits became mandatory. As relevant to the present situation, Section 47B provides:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or

subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective . . . shall . . . provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

(c) In the case of outpatient benefits these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve.

Family Counseling and Guidance Centers is a group of approved mental health clinics, wherein treatment was rendered to employees of the General Electric Company.

Section 47B of Chapter 175 is applicable to certain group policies ". . . described in subdivision (A), (C), or (D) of section one hundred and ten which . . . (are) issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth . . ." In our view, Subdivisions (A), (C) and (D) of Section 110 apply only to policies delivered in the Commonwealth. Accordingly, Section 47B should be read to apply only to policies initially issued in Massachusetts which are subsequently renewed, within or without the

State. The Group Policy issued by Metropolitan to the General Electric Company was delivered in New York.

Also, as noted above, the requirements of Section 47B are only applicable to policies "issued or renewed (on and after January 1, 1976) by agreement between the insurer and the policyholder,". Since the law became mandatory, the policy issued to General Electric by Metropolitan has not been renewed by agreement between the parties. Rather, General Electric has continued coverage in force by continuation of premium payments. For that reason, it is our view that the statute is not applicable to the General Electric policy.

Also, the Group Policy issued by Metropolitan to General Electric reflects the results of collective bargaining agreements between General Electric and the unions representing its employees. Under federal labor policy, statutes like Section 47B cannot alter these negotiated benefits. Then, too, serious constitutional questions arise if the statute is applied extraterritorially to the General Electric policy which was delivered in New York. If the insurance departments attempt to apply these type laws extraterritorially, the resulting balkanization of group insurance will so increase the cost of administration as to eliminate the very economies which have enabled group insurance to provide low cost coverage for an ever-increasing segment of the population. It will also have the undesirable effect of forcing employers to establish fully self-insured arrangements.

We would be happy to discuss the matter further, should you deem it to be appropriate.

Very truly yours

/s/ G. L. White
Vice-President

August 16, 1978

EXHIBIT C(2)(c)

[SEAL]

THE TRAVELERS
THE TRAVELERS INSURANCE COMPANY
One Tower Square
Hartford, Connecticut 06115

GROUP DEPARTMENT

October 14, 1976

Mr. John Petropoulos
Senior Insurance Examiner
Department of Banking and Insurance
Division of Insurance
Leverett Saltonstall Building
Government Center
100 Cambridge Street
Boston, Massachusetts 02202

Dear Mr. Petropoulos:

Re: Melville Shoe Corporation
—File No. 192 HS 56668

National Standard Corporation
—File No. 192 HS 46610

This will refer to your telephone conversation and correspondence with Supervisor J. E. LeBlanc, Claim Department. Our concern, and I believe yours, has to do with Chapter 1174, L'1973 which provide for coverage for mental illness under a statute which by its terms would attempt to qualify as an extraterritorial statute. The language of the statute refers to hospital expense and surgical expense insurance which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, during the period the provision is effective.

There has been much talk in this correspondence, and presumably in the phone conversations, which indicate The Travelers' Accident and Health Policy is renewable. This is not the case. For a number of years The Travelers' Group Insurance Policy has provided for automatic continuation of the coverage so long as the policyholder pays the premium. One option we have allowed ourselves is to discontinue the policy if, in fact, the requisite participation under state group statutes has not been met.

Otherwise no other alteration of the policy to include new statutory provisions of any state is available to the insurer under these policies. Both of the captioned policies are issued outside of the Commonwealth.

There is another reason to feel this statute may not be enforceable. The policy is issued to cover the employer's obligations as sponsor of an employee welfare benefit plan under Section 402, Employee Retirement Income Security Act of 1974. The policy is not intended to broaden that plan by incorporating coverages not applied for by the employer.

The constitutionality of such a requirement is suspect as interference with contracts concluded in other states and as interference with the collective bargaining process governed by the NLRA. The importance of these arguments is strengthened by the fact that a State's regulatory legislation affecting insurance companies is preempted as to employee benefit plans by Section 514, ERISA. This Section has been tested recently in *Azzaro v. Harnett*, 75 Civ. 3631 (CMM), June 3, 1976 in the United States District Court for the Southern District of New York. The Court concluded that this preemption clause was to be interpreted broadly as precluding the application of state insurance laws and regulations to employee benefit plans. Under the holdings of this decision, it would seem doubtful that, were the matter litigated, a District Court would enforce the inclusion of

the Chapter 1174 benefits in the policy if inclusion of the same benefits in the plan would be considered unenforceable, and this particularly if no premium had been collected for the benefit.

We are, of course, providing for the benefit in policies we issue in Massachusetts.

I trust that this will clarify our position that (1) the policies, issued before the effective date of the Massachusetts law, are not renewable, and for this reason not unilaterally alterable by the insurance company; and (2) the application of the law extraterritorially would not appear supportable under the current interpretation of the Federal law governing employee benefit plans.

Very truly yours,

/s/ H. M. Spencer, Jr.
H. M. SPENCER, JR.
Secretary

HMS:hr

EXHIBIT C(2) (d)

[SEAL]

THE TRAVELERS
THE TRAVELERS INSURANCE COMPANY
One Tower Square
Hartford, Connecticut 06115

GROUP DEPARTMENT

May 26, 1977

Mr. Michael Unger,
Director of Legal Services
State of Massachusetts Insurance Department
Leverett Saltonstall Building
Government Center
100 Cambridge Street
Boston, Massachusetts 02202

Dear Mr. Unger:

Re: GTE Laboratory, Inc.
Group Policy No. GA-463000AC
493-HS-19034

This will serve to acknowledge receipt of your letter of March 15, 1977 to Assistant Manager Jordan of our Danvers, Massachusetts Claim Office.

We wish to refer you to the collective bargaining agreement between the Danvers Plant of GTE Sylvania, Inc. and Teamsters Local No. 42, A/W International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, for the period from September 20, 1976 to September 21, 1979. This collective bargaining agreement, specifically Appendix C—Employee Group Insurance and Benefit Plan, Page 66, provides as follows:

The outpatient psychiatric benefit for employees only shall be improved to provide:

a) payment for the full cost of the first two visits to a clinic or psychiatrist based on reasonable charges,

b) payment of $34.00 for remaining visits to a psychiatrist or $17.00 for clinics.

c) that payment for visits to a clinic or psychiatrist will be limited to the first two visits mentioned in a) above and an additional fifteen visits mentioned in b) above per twelve month benefit period.

d) that a "clinic" will qualify for coverage only if it is affiliated with a state licensed hospital.

The above is the basis for GTE bargaining and benefits throughout the country. The plan of GTE Laboratories Incorporated contains these exact benefits.

We note the language of Section 47B, Chapter 175, of the Massachusetts Statutes, "which is issued or subsequently renewed by agreement between the insurer and the policyholder, *within or without the commonwealth*", modifies the preceding language "Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten . . .". Obviously this refers to policies issued in Massachusetts, because a Massachusetts statute cannot mandate the types of policies issued in other states. The GTE policy is issued in Delaware and is subject to the laws of that state.

Furthermore, the GTE policy has not been renewed since the effective date of the statute (January 1, 1976). We stopped renewing our policies many years ago; rather the policy continues in force indefinitely until the policyholder fails to remit premium or gives us notice that it wishes to discontinue. We have no right to unilaterally

alter an existing contract, including its cancellation, except when it no longer meets the requirements of the Delaware statute.

Finally, we note that the obligation under the statute is levied on insurance policies and not on employers. The Employee Retirement Income Security Act of 1974, specifically Section 514, denies to Massachusetts the right to regulate the "employee benefit plan" of GTE. If The Travelers were to provide a mental and nervous benefit under the group insurance policy that an employer has not agreed to, the employer under ERISA could seek to enjoin us in federal court from violating its collective bargaining agreement by providing benefits not provided by its employee benefit plan.

I trust the foregoing will explain our reluctance to attempt to force adherence to your statute.

Sincerely,

/s/ Timothy F. Lyons
TIMOTHY F. LYONS
Assistant Secretary

TFL:hr

cc: Manager Keller, LAG/RAM Claims, Danvers

EXHIBIT C(2)(e)

THE TRAVELERS
THE TRAVELERS INSURANCE COMPANY

[SEAL]

One Tower Square
Hartford, Connecticut 06115

GROUP DEPARTMENT

June 16, 1977

Mr. John Petropoulos
Insurance Examiner
Consumer Service Section
The Commonwealth of Massachusetts
Division of Insurance
Leverett Saltonstall Building
100 Cambridge Street
Boston, Massachusetts 02202

Re: Arthur Sorenson, Exec. V.P.
Communications Workers of America
147 Milk Street, Room 702
Boston, Mass. 02109

Dear Mr. Petropoulos:

We have your May 20 letter regarding the above.

As stated in our previous letter, we believe the reference in Chapter 175, Section 47B of the Massachusetts Laws to a policy described in Subdivision (A), (C), or (D) of Section 110 of Chapter 175, issued or subsequently renewed "within or without the Commonwealth" is limited to a policy originally isssued in the Commonwealth since only such policies are subject to the requirements of Section 110. The Massachusetts legislature cannot mandate provisions to be included in policies issued in other juris-

dictions. Since the policy issued by The Travelers to the American Telephone and Telegraph Company, Long Lines Department was issued in New Jersey, its provisions are subject to the requirements imposed by that state.

Moreover, the mandate under Chapter 175, Section 47B applies to insurance policies not employers. The Employee Retirement Income Security Act of 1974 in Section 514 denies to Massachusetts the right to regulate an employer's "Employee Benefit Plan".

In addition the policy in question reflects the benefit provisions of the Medical-Surgical portion of the Basic Medical Expense Plan, Extraordinary Medical Expense Plan and Special Medical Expense Plan as outlined in the 1974 bargaining agreements between the telephone company and the Communication Workers of America, 1925 K Street N.W., Washington, D.C. 20006. Copies of these agreements are distributed or made available to all individuals covered thereby.

This same question has been raised by one Jonathan Bauer, (dependent Peggy) under a group policy issued to GTE Laboratory, Inc. which has been the subject of correspondence between our company and Mr. Michael Unger, Director of Legal Services for your Department.

While The Travelers stands ready to provide benefits as prescribed by Chapter 175, Section 47B, to any group policyholder, we trust you will appreciate our inability to force a group policyholder to purchase particular benefits or to violate its collective bargaining agreements.

Sincerely,

/s/ Harriett S. Olzendam
HARRIETT S. OLZENDAM
Secretary

HSO:bab

[Exhibits C(3) and C(4) have been omitted. They appear at pages 34 and 35 of the appendix filed by the parties in the Supreme Judicial Court for the Commonwealth of Massachusetts. A copy of that appendix has been lodged with the Clerk of this Court.]

EXHIBIT D

AFFIDAVIT OF CAROLYN A. LAMARRE

1. My name is Carolyn A. LaMarre. I am employed by the Massachusetts Association for Mental Health, Inc. (MAMH), 1 Walnut Street, Boston, as the Liaison to Mental Health Chapters and Mental Health Organizations. I have held this position since 1977.

2. MAMH, formed in 1913, is a private, non-profit citizens organization working for quality mental health care in Massachusetts. The thrust of MAMH's programs is social action and public education. To achieve these objectives, MAMH participates in the planning and implementation of mental health legislation and services; evaluates and develops specific services, and promotes public understanding. MAMH is a division of the National Mental Health Association. Within Massachusetts, MAMH has 26 Affiliated Chapters, 7 Allied Organizations, and works closely with the Coalition of Community Mental Health Partners, a group of 46 state and locally funded mental health clinics.

3. My duties consist of advising mental health organizations on policies, methods, and procedures in matters pertaining to mental health programs as well as providing technical assistance in areas of program development, budgeting, and financing.

4. It came to the attention of MAMH in June, 1977 that the local mental health clinics, jointly financed by state and local funds, were having collection problems with commercial insurance companies under group policies written outside of the Commonwealth of Massachusetts covering Massachusetts resident subscribers. It was our belief that this practice denied residents the benefits required by Chapter 1174 of Acts of 1973.

5. During 1978, I conducted two surveys to assess the impact on the clinics and Massachusetts residents of the

lack of compliance with Chapter 1174. MAMH conducted these surveys with the intention of reporting the results to the Attorney General. In addition to the formal surveys, I spoke to many clinic directors, and employees about this problem.

6. The first survey was conpleted in April, 1978. With 55% of the clinics (26 clinics) responding, 273 instances of nonpayment or partial payment by insurance companies in a 6 month period were identified. From the survey, and from my discussions with the clinics, three basic reasons for nonpayment emerged: (1) companies will not pay for treatment of a Massachusetts resident covered under a group policy issued out of state; (2) companies will not reimburse for treatment provided by licensed psychologists and (3) companies will not apply Chapter 1174 to policies issued prior to January 1, 1976.

7. In the summer and fall of 1978, I conducted a second survey to gather more specific data from selected clinics which had reported extensive nonpayment problems. These clinics were distributed throughout the state. The survey results demonstrated that the Travelers Insurance Company and the Metropolitan Life Insurance Company were consistently failing to provide the Chapter 1174 benefits. The insurance company correspondence solicited by the survey, and attached hereto, show that reason for nonpayment is most often that the contract is issued out-of-state (or the related rationale that services of physicians only are covered). The results of this survey were sent to the Attorney General on December 8, 1978.

8. Clinics have responded to the failure of certain insurance companies to reimburse for the treatment in three different ways: (a) some clinics require that clients with insurance coverage pay the full amount of the fee even though the company refuses to pay. Though it is difficult to determine the extent, it is probable that this policy deters clients from securing clinical services or limits the number of sessions they can afford; (b) some

clinics put the client whose company refuses to pay on a sliding scale fee based on their ability to pay a portion of the total cost for the clinical service; (c) some clinics totally absorb or write off the cost of services to clients whose companies refuse to pay.

9. Where clients are serviced "free" or are subsidized on a sliding scale (8b and c above) the clinic's capacity to serve the community is reduced. Since the money used by the clinics in these situations to cover the deficit of the cost for care is derived from appropriated state reimbursements (see attached letter of the Rate Setting Commission from the Department of Mental Health 8/24/78) or local municipal allocations, the use of these funds for insurance company nonpayment prevents their expenditure for other purposes. All of the clinics citing difficulties with Travelers and Metropolitan have client waiting lists. The use of state and local funds to subsidize insurance nonpayment depletes funds which could otherwise increase staffing to serve those waiting lists. Also if staffing and funds were available, clinics could conduct more outreach and services to citizens who have mental health service needs.

Signed under the PAINS and PENALTIES of PERJURY this 9th day of May, 1979.

/s/ Carolyn A. LaMarre
CAROLYN A. LAMARRE

EXHIBIT D(1)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

August 8, 1978

North Shore Guidance Center
162 Federal Street
Salem, Ma. 01970

Attention: Leona Pelletier
Insurance Secretary

Subject: GTE Sylvania, Inc.
Group Policy: GA463000AA
Re: Group Health Claim

Dear Ms. Pelletier:

I have received your letter dated June 26, 1978, in regard to services rendered on March 16, 1977 to . In addition, I note your references to Massachusetts General Laws, Chapter 1174.

The subject contract with GTE Sylvania was issued in the State of Delaware and not in the Commonwealth of Massachusetts and, therefore, Chapter 1174 is not applicable.

If you have any further questions, please feel free to contact me.

Sincerly yours,

/s/ Daniel W. Jordan
DANIEL W. JORDAN
Assistant Manager

DWJ:amc

EXHIBIT D(2)

[SEAL]

THE TRAVELERS

Group Claim Department
C. J. Keller, Manager

October 13, 1977

Framington, Mass.

For:
File Number: 493 HS 41998
Policyholder: GTE Sylvania

Dear Mr.

We have received a statement from Bea Dube, Ph.D. for services rendered.

We regret that we are unable to consider this expense for payment because your group insurance policy allows us to make payment for treatment rendered *only by a duly qualified physician.*

In no way do we question the professional competence or quality of the care received. Our decision is based solely on the policy language which requires that the services be rendered by a duly qualified physician.

Very truly yours,

/s/ Kathleen D. Farrar
KATHLEEN FARRAR
Group Claims Processor

KF/jp

EXHIBIT D(3)

METROPOLITAN LIFE INSURANCE COMPANY
402 East Street
Pittsfield, Mass. 01201
Telephone: (413) 447-7336

Frederick C. Bradley
Group Claim Consultant

June 2, 1978

Mr. John S. Greco—Manager
Benefits Accounting &
Claims Administration
Large Transformer Finance Operation
General Electric Company
100 Woodlawn Avenue
Pittsfield, Ma. 01201

Re: 91452

Dear Mr. Greco:

The only psychiatric treatment covered under the General Electric Group Plan is that which is personally administered by a licensed psychiatrist or psychologist.

Therefore, we regret very much that no benefits are payable with regard to the $1155. in fees for therapy provided by Frances Vaughn (even though this treatment was supervised by Dr. Northrup).

Yours truly,

/s/ F. C. Bradley
F. C. BRADLEY
Group Claim Consultant

dmn

EXHIBIT D (4)

[SEAL]

METROPOLITAN LIFE INSURANCE COMPANY
530 Franklin St.
Schenectady, N.Y. 12305
Telephone: (518) 374-9177

Frederick C. Bradley
Group Claim Consultant

PR 14
SS#
7/27/78

Ms. Leona Pelletier
Insurance Secretary
North Shore Guidance Center
and
Health & Education Services, Inc.
162 Federal Street
Salem, Massachusetts 01970

Re: General Electric Company
Policy G-17500

Dear Ms. Pelletier,

Your letter of June 26, 1978 addressed to the General Electric Company has been referred to my attention.

The matter as regards M.G.L. 1973 Chapter 1174, Section 4 is under consideration by the Metropolitan Life Insurance Company's Legal Department together with the Insurance Department of the Commonwealth of Massachusetts. Until the matter is resolved to the mutual satisfaction of both parties, we will continue to process claims in accordance with the provisions of the existing General Electric Company Group Contract.

The General Electric Plan pays benefits on the cost of psychotherapy personally administered by a licensed psychiatrist or a licensed psychologist.

Yours truly,

/s/ Frederick C. Bradley
FREDERICK C. BRADLEY
Group Claim Consultant

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

Suffolk, ss.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Jul. 16, 1979]

ANSWER OF THE TRAVELERS INSURANCE COMPANY AND METROPOLITAN LIFE INSURANCE COMPANY

First Defense

The defendants, The Travelers Insurance Company and Metropolitan Life Insurance Company, answer the correspondingly numbered paragraphs of the plaintiff's Complant as follows:

1. The defendants admit the allegations contained in the first sentence of paragraph 1. The defendants further admit that the complaint seeks preliminary and permanent injunctions as specified in prayers 2 and 4, respectively. Except as admitted herein, the defendants deny the allegations of paragraph 1.

2. The defendants admit that subject matter jurisdiction is conferred on the Court by G.L. c. 214, § 1. The defendants deny the remaining allegations of paragraph 2.

3. The defendants admit that they have each received notices advising them that the Attorney General intended to file suit, purportedly to enforce the provisions of G.L. c. 175, § 47B. The defendants deny the remaining allegations of paragraph 3.

4-6. The defendants admit the allegations contained in paragraphs 4-6.

7. The defendants admit that they have each been licensed by the Commonwealth of Massachusetts to transact the business of insurance within that state, and that such licenses, issued on a periodic basis, have been regularly in force with regard to each of them for over 100 years. The defendants further admit that each of them transacts the business of insurance in other sovereign states of the United States of America. Except as admitted herein, the defendants deny the allegations of paragraph 7.

8. The defendants admit that in the course of its business each defendant issues group insurance policies, some of which provide coverage for hospital and surgical expense incurred by insureds who are residents of the Commonwealth of Massachusetts. Except as admitted herein, the defendants deny the allegations of paragraph 8.

9. The defendants admit that many of their group insurance policies are issued to implement employee welfare benefit plans. The defendants deny the remaining allegations of paragraph 9.

10. The defendants admit that G.L. c. 175, § 47 B was enacted on December 10, 1973, became effective in its present form on January 1, 1976, and contains, in part, the provisions quoted in paragraph 10 of the Complaint. Except as admitted herein, the defendants deny the allegations of paragraph 10.

11. The defendants admit that since January 1, 1976, they have each issued more than one group insurance policy to policyholders who are situated outside the Common-

wealth of Massachusetts, some of which policies provide coverage for certain hospital and surgical expenses incurred by insureds who are residents of the Commonwealth of Massachusetts. The defendants further admit that certain of these polices do not provide coverage for residents of Massachusetts of all expense arising from the mental or nervous conditions referred to in G.L. c. 175, § 47B. The defendants deny the remaining allegations of paragraph 11.

12. The defendants admit that they have offered to issue group insurance policies to prospective policyholders, some of which are situated outside the Commonwealth of Massachusetts, and that a portion of the potential insureds on some of those policies are residents of the Commonwealth of Massachusetts. The defendants deny the remaining allegations of paragraph 12.

13. The defendants admit that they have issued group insurance policies, effective prior to January 1, 1976, which do not contain provisions affording defendants the unilateral right to non-renew the policies. The defendants admit that such policies provide them with the right to change the premiums. The defendants admit that all the parties to such policies may alter other policy terms and benefits by agreement, and that such policies have been issued both within and outside the Commonwealth providing coverage for insureds who are Massachusetts residents. The defendants deny the remaining allegations of paragraph 13.

14. The defendants admit that since January 1, 1976, each of them has changed the premiums due on some of the policies referred to in their answer to paragraph 13 of the Complaint, and they admit that they have each agreed with some of their policyholders to alter the terms and the premiums of certain other such policies. The defendants deny the remaining allegations of paragraph 14.

15. The defendants admit that certain of the policies referred to in their answer to paragraph 14 of the Complaint do not provide coverage for all expense arising from the mental and nervous conditions referred to by G.L. c. 175, § 47B. The defendants deny the remaining allegations of paragraph 15.

16. The defendants admit that they have responded to requests to provide coverage for certain expenses incurred by some Massachusetts residents stating that the group insurance policies under which those residents are otherwise insured do not provide coverage for all expense arising from the mental and nervous conditions referred to by G.L. c. 175, § 47B, and they admit that those responses were based in part upon the reasons set forth in subparagraphs (a) through (d) of paragraph 16 of the Complaint. The defendants deny the remaining allegations of paragraph 16.

17. The defendants deny the allegations of paragraph 17.

18. The defendants deny the allegations of paragraph 18.

Second Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance written to implement employee benefit plans described in § 1003(a) of Title 29 of the United States Code, its application to such contracts would be preempted by and in conflict with the Employee Retirement Income Security Act of 1974, codified in that Title, and the statute would thereby be repugnant to the Constitution and laws of the United States.

Third Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into in order to implement collective bargaining

agreements covered by and subject to the federal labor laws, 29 U.S.C. §§ 141 et seq., including the National Labor Relations Act and the Railway Labor Act, its application would be preempted by federal labor law and the statute would thereby be repugnant to the Constitution and laws of the United States.

Fourth Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into outside the Commonwealth of Massachusetts, its application would create an unreasonable burden upon interstate commerce such that the statute would be repugnant to the Constitution of the United States.

Fifth Defense

If the statute asserted and relied upn by the plaintiff were to be construed to reach contracts of insurance entered into outside the Commonwealth of Massachusetts, it would constitute an attempted extraterritorial exertion of the Commonwealth's authority repugnant to the due process limitation placed upon the States by the Constitution of the United States.

Sixth Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into in and governed by the laws of other sovereign States, its application would constitute an attempted extraterritorial exertion of the Commonwealth's authority repugnant to the Full Faith and Credit Clause of the Constitution of the United States.

Seventh Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance

entered into in and governed by the laws of other sovereign States, its application would be an attempted extraterritorial exertion of the Commonwealth's authority in conflict with the sovereign rights reserved to her sister States and repugnant to the Constitution of these United States.

Eighth Defense

If the statute asserted and relied upon by the plaintiff were to be construed to reach contracts of insurance entered into prior to its effective date, it would constitute a law impairing the obligation of contracts repugnant to the Constitution of the United States.

Ninth Defense

Each defendant is exempt from Chapter 93A of the General Laws of Massachusetts by virtue of the provisions of Section 3(1)(b) of that chapter.

Tenth Defense

The plaintiff is guilty of such laches as should in law and equity prevent it from obtaining the relief sought.

By their Attorneys,

/s/ Lane McGovern
LANE MCGOVERN

/s/ William S. Eggeling
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Dated: July 17, 1979

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT

No. 35598

SUFFOLK, SS.

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

ORDER

This matter came to be heard on the Commonwealth's motion for a preliminary injunction and after a hearing thereon, it is ORDERED, ADJUDGED, and DECREED: that upon payment to the clerk of the sum of $5.00 the application is hereby granted and it is ordered:

Pending the trial and determination of this action, the defendants are restrained from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175 § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976.

This preliminary injunction shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants since January 1, 1976 has not provided the benefits required by G.L. c. 175 § 47B at any time since January 1, 1976, the defendants shall, within 30 days of this ORDER, provide to each such policyholder

copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this ORDER. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT CHANGES FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A PRELIMINARY INJUNCTION ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORZANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976 FOR WHICH YOU DID NOT

RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

THIS BENEFIT CHANGE WILL REMAIN IN EFFECT PENDING FINAL RESOLUTION OF THE LITIGATION INSTITUTED BY THE ATTORNEY-GENERAL OF MASSACHUSETTS.

2. Commencing 30 days from the effective date of this order, the defendants shall pay expenses for benefits required by G.L. c. 175, § 47B on claims submitted by subscribers for services rendered at any time since January 1, 1976 on policies issued since January 1, 1976.

/s/ George S. Mitchell, J.
Associate Justice
Superior Court

Entered: August 28, 1979

[TRANSCRIPT OF PROCEEDINGS]

[1-29] TESTIMONY OF JAMES M. DAWSON

DIRECT EXAMINATION
BY MR. GREENFIELD:

Q Please state your name and address.

A My name is James M. Dawson, 51 Platts Avenue, Manchester, New Hampshire.

Q And what is your present employment?

A I'm an administrator of welfare and pension funds.

Q And what is the name of the entity under which you operate?

A I am president of James M. Dawson, Associates, Incorporated of Manchester.

Q And what is the address of that?

A 472 Chestnut Street, Manchester, New Hampshire.

Q Could you describe what the business of James M. Dawson, Associates, Inc. involves?

A Yes, we are in the business of establishing and administering health and welfare plans and pension plans which are negotiated plans between organized labor and their employers.

Q And since when have you been involved in this type [1-30] work?

A Since 1953.

Q What happened in 1953?

A In 1953 I was employed as a plumber, Local 564, and we negotiated the first employee benefit plan that I am aware of in the State of New Hampshire for the plumbers local, and I was asked to be the first administrator for that plan.

Q What were the circumstances that led to your being asked to be the administrator of that plan?

A I was vice-president of the plumbers local. I was also a member of their negotiating bargaining committee, and it was my desire—the members of the union at that

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* The numbers in brackets refer to the page numbers in the trial transcript.

time had no insurance—that they somehow have insurance provided for them by the employer. In fact, plumbers are an itinerant group. They move from employer to employer as the work load presents itself, and for that reason many of them never stayed with one employer long enough to be covered by any insurance plan that that employer might have. And so I conceived of the idea of setting up a trust fund where each employer would pay into that trust for all the hours work for each of his employees, and that trust would be used to purchase [1-31] insurance for the plumbers regardless of which employer they were working for.

We sat down with the employers. We discussed what we wanted for a package of benefits, and after extensive negotiations they finally agreed to give us a minimum package of benefits which they would support with contributions, and a board of trustees under the rules of Taft-Hartley was established. A trust fund was established, and I was selected to be the first administrator as well as one of the trustees of that plan.

Q Did that plan cover plumbers only, or did it also cover steam fitters?

A It covered plumbers and steam fitters.

Q Did you establish welfare plans in trades other than plumbers and steam fitters?

A Yes, I did.

Q Could you tell us in what trades?

A I established them in the masons and bricklayers, plasterers, carpenters, sheet metal workers, electrical workers, painters, and construction drivers.

Q Could you briefly describe how it came about that you established plans for these other trades as well?

A The plumbers plan that we established apparently went [1-32] very well. The unions were very happy with it, and the employers were very happy with it. So some of the other plans came to me and asked me if I would help them to establish a plan between their respective unions and their employers, and I agreed that I would help

them establish. Once the plan was established in each case, they asked me if I would be the administrator.

Q You actually participated in the bargaining negotiations?

A Yes, I actually went to the negotiating table with the unions and sat down and told them what package of benefits—suggested what package was available. In fact, I even went to the union meetings themselves and described with the membership what benefits were available, gave them estimates about what it would cost, discussed rules of eligibility with them, and so forth; and after they had instructed their negotiating team what they wanted, I went with the negotiating team to the employers, explained what the situation was. In each case we were successful in negotiating the conditions for a welfare plan.

Q Now, these various plans that you mentioned in these trades, did any of them exist before you became [1-33] involved with them?

A No, they did not.

Q You formed each one?

A Yes, I did.

Q Are you a member of any industry organization?

A Yes, I am.

Q Which ones?

A The International Society of Professional Benefit Administrators and the International Foundation of Employee Benefit Plans.

Q Could you describe what these associations are?

A The International Foundation of Employee Benefit Plans is an educational organization headquartered outside of Milwaukee in the town of Brookfield, Wisconsin, dedicated entirely to the education of trustees and administrators and professionals in the field of employee benefit plans to the applicable laws and economics of employee benefit plans. The Society of Professional Benefit Administrators is made up entirely of third party contract administrators, as I myself am, and we are concerned with

applicable laws and the problems and so forth involved in the administration of plans.

Q Since when have you been a member of the International [1-34] Foundation?

A I believe in 1947 I joined.

Q '47 or '57.

A 1947 I believe I joined. I'm sorry, no, '57.

Q Do you hold any offices in either of these associations?

A I'm on the Board of Directors of the International Foundation. I am Chairman of their Budget and Finance Committee. I am on their Educational Program Committee. I have previously served as Chairman of their Administrators Committee, was on the Regionals Committee, and I was on their Administrative Cost Study Committee. The Society of Professional Benefit Administrators, I served on the Board of Directors, and I am also chairman of their Preemption Committee.

Q What do you mean by Preemption Committee?

A We are studying the problems of preemption as it refers to administration of plans and seeking ways to solve the problems involved in preemption.

Q Now, are you affiliated with any schools?

A Yes, I am on the Advisory Council of New Hampshire Technical Institute in Concord, New Hampshire.

Q Are you affiliated with any banks?

A Yes, I am on the Board of Directors of the Manchester Bank.

[1-35] Q Are you affiliated with any mental health problems?

A Yes, I am one of the incorporators of the Mancester Mental Health Center.

Q Are you affiliated with any planning committees?

A Yes, I am on the Southern New Hampshire Planning Council.

Q Have you published any articles relating to benefit plans or such subjects?

A Yes, I have. In 1961 I published an article in their textbook for fund administration, published by the International Foundation. In 1970 I published an article in their new textbook on welfare fund administration. I published an article in 1969 in the winter issue of New Hampshire Bar Journal entitled "Role of Attorney in Welfare Pension Funds." In 1976 I wrote an article for the International Digest. In 1977 I published another article in their textbook on welfare fund administration. In 1978 I published an article in the Journal of pension and planning compliance. In 1979 I published an article in the textbook for trustees and administrators of employee benefit plans, and in 1977 I published another article on reciprocity for employee benefit plans. In 1978 I produced an article in Employee Benefits Journal.

[1-36] Q Have you given any speeches in this area?

A Yes, in 1961 I was a speaker at the International Conference of the Foundation. In 1970 I was a speaker. In 1974, 1975, 1977, and 1978 and 1979 and 1980 I was a speaker at various seminars and institutes by the International Foundation?

Q On what subjects?

A On reciprocity, fund administration, ERISA.

Q Now, how many employee welfare funds do you personally administer?

A Eight.

Q Could you tell us the names of those funds and the number of persons covered by them?

A Yes, the New Hampshire-Vermont Mason Health and Welfare Fund has approximately 619 employees with 1,800 dependents. The New Hampshire Construction Drivers have approximately 102 employees with 306 dependents. The Painters Local 1042 has approximately 72 employees and 14 dependents. IBEW, that's Electrical Workers, Local 719—

Q Is that the International Brotherhood of Electrical Workers?

A Yes, it is. 187 employees with 561 dependents. IBEW Local 421, has 90 employees, 270 dependents. Sheet [1-37] Metal Workers 297, 128 employees, 384 dependents; Plumbers Local 131, 944 employees, 2,832 dependents; Northern New Enland [*sic*] Carpenters Health and Welfare Fund, which is a tri-state plan for Maine, New Hampshire, and Vermont, covers 3,285 carpenters and 1,855 dependents.

Q Is it fair to say that the employees in your plans tend to reside in Maine, New Hampshire, and Vermont?

A Yes, they do.

MR. GREENFIELD: Your Honor, I would move that Mr. Dawson be declared an expert in the field of the administrator of employee welfare plans.

THE COURT: Mr. Attorney General?

MR. MONTGOMERY: No objection, your Honor.

THE COURT: Okay.

Q Now, you mentioned the term ERISA. What do you understand ERISA to be?

A ERISA is the Employee Retirement Income Security Act of 1974, a very broad comprehensive law dealing with employee benefit plans, primarily brought about by Congress to protect the interests of the employees and to provide for stability and uniformity in their plans within the United States.

MR. MONTGOMERY: Objection, your Honor. I [1-38] don't believe that Mr. Dawson is qualified to testify with respect to the intent of Congress in enacting that legislation.

THE COURT: That portion may be stricken. The rest may stand, however.

Q Just give your understanding of it, yes. Now, as you understand it, are each of the funds that you administer within ERISA?

A Yes, they are.

Q Are they known as ERISA plans?

A Yes, they are.

Q I think you mentioned the Taft-Hartley. What do you understand in term Taft-Hartley Trust to mean?

A Taft-Hartley refers to the Labor Management Relations Act which I understand to be an act that provides for an exemption from the prohibition against employers contributing anything of value to an employee representative, and the exception is except for contributions to a welfare or pension fund and other funds in there that are also included. They set forth specific conditions. There must be a trust. Labor and management must be equally represented on that trust. Funds for each fund must be kept separate. Basically, I think that's the concept of what a [1-39] Taft-Hartley trust is.

Q And as you understand it, are each of the funds that you administer Taft-Hartley trusts?

A Yes, they are.

Q Now, could you explain in general terms how these funds are established and how they actually operate with respect to benefits?

A Yes. When a group, a union usually, decides that they want to establish a welfare or pension fund, usually the union itself discusses that at the time of negotiations for wage package. Usually I am invited to go to the union meeting and to address the members of the union and discuss with them possible coverages, what those coverages would cost, what their rules of eligibility would be in order that they might have one of these funds; and then normally I am invited to go to the wage negotiations so that the employers might be able to ask me questions that they might have regarding costs and operation of the plan, and so forth. If the unions are successful in negotiating with the employers a contribution to the plan, at that time a board of trustees is selected with equal representation between management and labor, and the trustees, with me helping [1-40] them, usually send the specifications that we have decided on, that is, the package of benefits, to various insurance companies and ask them to bid on the package. After

the sealed bids are received in my office they are reviewed by the trustees, and the insurance providing the best price and conditions are usually selected. At that point an administrator is selected, and, fortunately, in most cases that was our firm.

Q Now, at the bargaining table between the unions and the employers what role do benefit plans play in the actual negotiations?

A Well, we discuss with the employer what we want. We might tell them we want surgical benefits, hospitalization, life insurance, weekly income protection, vision, dental, whatever the package that the union selects they want. Obviously, you don't get everything you ask for. The employers say—it might say, "Fine, we'll give you hospitalization and surgical, but that's all we can afford this time." So, it's actually a tradeoff between what they want and what the employers are willing to give them. So after hard negotiations they wind up with a minimal package and hope that the next time around [1-41] they'll add a few more benefits.

Q Would you say that health benefits play an important or unimportant role in the actual negotiations between employer and employees?

A I would say that the last few years it's one of the dominant roles.

Q What is the reason for that?

A Simply because health care costs have escalated so tremendously, far more than any other segment of our economy, in my personal experience. Therefore, the members are aware of these extremes costs. It's my personal feeling that a person can't afford not to have insurance in this day and age. Consequently most of the members feel that way about it, and to them—I've seen negotiations where no other benefit was discussed other than health care or pensions.

Q With respect to how the actual negotiations take place, could you give the Court an example of what hap-

pens, taking for that example, perhaps, the recent negotiations with the plumbers?

A Well, the plumbers came into their negotiations, and they felt that they would need a dental program that would provide a maximum of $1,000 a year for each member and their dependents. They felt that they [1-42] needed a maximum of $125 for a pair of glasses, and normally they are allowed one pair of glasses every two years in most of our plans. When the negotiations were all over, they received from their employer enough to pay for $200 maximum for the member, $200 for his spouse, and $100 for each child under a dental program. They received a maximum of $75 for any member every two years on the vision.

Q Now, you referred earlier to the fact that you actually attended union meetings at which benefits are discussed. Could you describe in general the nature of those discussions?

A Well, I go to the union meetings, and we tell them—we suggest to them the various types of coverages that are available to us. Some coverages they turn thumbs down on absolutely. They are not interested at all. Other benefits they feel—you have a man stand up and say, "Lookit, I've got a child at my house that's got a mouth full of cavities, and I certainly feel we've got to provide dental coverage." Another young fellow, particularly, will get up and say, "Lookit, I think maternity benefits are an absolute must in this particular case." Somebody else will say, "Lookit, I've got a child here that [1-43] can't even get passing grades in school because she needs a pair of glasses so bad, and I can't afford the pair of glasses." That's the type of give and take that you have at the union meeting where members actually get up and vocalize very vehemently about what they personally feel is needed in their particular family. After the discussions are all over, the union actually takes a vote, and the predominent view prevails.

Q The predominent view as to which benefits to seek?

A That's right.

Q Has anyone at any of these meetings ever expressed a need or desire for mental health benefits?

A No, they haven't.

MR. MONTGOMERY: Objection.

THE COURT: I'll allow it.

Q Now, you used earlier the term "eligibility list." Could you tell the Court what an eligibility list is and the role that it plays in the negotiating and in the actual administration of welfare plans?

A Yes, I will. Obviously every one of these benefits that the union asks for has a cost attached to it. In order to be able to determine what number of cents per hour an employer would have to contribute on behalf of their members—As I previously explained, [1-44] these are itinerant workers who may work two or three weeks for one employer and then go to someplace else. So no employer is going to say, "I'm going to pay the cost of that particular program" because the worker doesn't stay with him long enough, so it has to be based on a cents per hour. Now, in order to intelligently decide how many cents per hour we are going to have to tell the union they need, we have to know how many hours they are going to agree that they have to work in a given period. Normally, in the construction industry we divide the eligibility into two periods a year, every six months. So then the decision has to be made of how many hours we will require an employee to work in a six-months period. Now, initially most of these plans had either 400 or 600 hours in a six-months period in order to become insured. Now, that meant that a person would only have to work about half time because if a person were to work six months at full time, he would work approximately 1,020 hours in that period of time. Now, if you require him to work 600 hours, we would normally expect that most of them could work 600 hours, so most of the plans with one or two exceptions were set at 600

hours for eligibility. [1-45] So an employee who worked 600 hours in a six-month period was then insured for the next following six-month period.

Q Now, if an employee meets the eligibility list requirements, he is then eligible for the full benefits?

A That's right.

Q And if he does not meet the eligibility requirements, what happens?

A He loses his insurance.

Q Now, at some point in the process of obtaining benefits for your plan, does insurance come in?

A Yes, everyone of the plans that I administer is insured.

A And you obtain bids from the various insurance carriers that you consider responsible?

A Yes.

Q Then you select that bid which is most favorable?

A That's right.

Q Now, what types of insurance policies do you enter into?

A Well, what we call experience rated policies.

Q Would you describe what that is?

A Yes, an experience rated policy is where that fund stands on its own feet as opposed to community rating. In other words, at the end of the year the insurance [1-46] company will actually come to us. Take the Carpenters Fund. In round figures they would pay the insurance company in premiums in one year approximately a million dollars. Now, at the end of the year the insurance company is going to come back to them and say to them, "You had in claims and retentions—" because that's part of the cost from the insurance company "—you had in claims and retentions $800,000. Therefore, we are going to give you a refund." They actually write us a check and give us a refund for $200,000 because that's the difference. However, if the experience is bad, the fund will then either be hit with a charge with whatever the excess is, $100,000 or so forth, or they

would run a deficit which will be carried forward to the next year and probably a rate increase, so that the $100,000 deficit will be recouped in a reasonable period of time.

Q Now, if it turns out that the amount paid in benefits by the insurance company is greater than the amount of premiums, as you understand it are you free to walk away from the policy and leave the insurance company holding the bag for that difference?

A Yes, we can.

Q Have there been occasions when the amount paid by [1-47] the insurance company exceeded the amount of the premiums?

A Yes, I can think of one particular case, two particular cases. At one particular time the carpenters were in the red, if you will accept that expression, for $325,000.

Q Do you mean by that that the claims paid exceeded the premiums by $350,000?

A That's right.

Q Continue.

A The masons just a short time ago, last year, ran up a deficit of $64,000.

Q Now, with respect to the carpenters, did you give consideration to changing carriers and leaving—Who was the carrier?

A The Lincoln National Life Insurance Company.

Q Did you give consideration to changing carriers and leaving Lincoln holding what we'll say is the bag for that $350,000?

A The trustees discussed it extensively.

Q And was something done similarly with the masons?

A Yes, it was.

Q Generally, what is the duration of the insurance policy that you buy?

[1-48] A One year contracts.

Q And how often are premiums paid?

A Semi-annually.

Q Under these policies, how are claims administrations handled?

A Normally the employee contacts our office. We give them a claim form. They complete the claim form, send it back to our office. We certify eligibility, check the claim to make sure that everything is in order, make a photocopy of it, and send it to Lincoln National. They pay the claim and take over from there.

Q Lincoln National is the carrier you are using predominently at this time?

A Yes, it is.

Q And you have used other carriers over the past?

A Yes, we have.

Q What is your reimbursement for this?

A We are paid a per capita for each employee.

Q Now, what are the alternatives open to a plan for providing benefits other than purchasing insurance policies?

A They can be uninsured.

Q What does that mean?

A That means that they can pay the claims right out [1-49] of the assets of the trust itself without any insurance company involved whatsoever.

Q Now, what are the advantages and disadvantages of having an insured plan as opposed to an uninsured plan?

A The advantages of an insured plan, in my personal opinion, are the great stability and the experience and the knowledge and know-how that any insurance company brings to the plan. There are times when there is a lot of unemployment. There is a time we have cash flow problems in the plan, and so forth, when the very viability or the very solvency of a plan could be jeopardized if they didn't have insurance. By having an insurance carrier there, and they have the know-how, they have the knowledge, experience. They can process claims.

As a third party payer they are not subject to the political pressures that would be evident if, for instance, my office was personally paying the claims. In other words, union members, trustees, and so forth, could come and put pressure on me and my employees to pay claims that normally should have been paid. That kind of pressure cannot be placed on a big insurance carrier. I, personally, feel that that is a tremendous advantage to the fund to have the insurance carrier there.

[1-50] The only disadvantage I see is the very fact that states can mandate benefits for an insurance carrier, but they cannot mandate benefits for the uninsured. Therefore, if we went uninsured—I do not like the term self-insurance because there is no insurance involved there at all. If they were uninsured, then they could not mandate the benefits, and the unions could control their own plans.

Q You gave an example before with respect to the carpenters, that the actual claims submitted one year was $350,000 greater than the premium, approximately.

A Yes.

Q What would have happened if that plan was uninsured?

A They would have been bankrupt. They could have gone out and borrowed money at high rates of interest, which to me would be self-destructing because they would have to reduce benefits. They would have to pay back that money eventually. They would have to pay interest on that money, and certainly they would have to increase eligibility and reduce benefits, and I feel it would be a disaster.

Q Now, in your industry is employment cyclical?

A It definitely is.

Q Is there any relation to bad weather and the amounts [1-51] available to pay for claims?

A Yes, there very definitely is.

Q Could you describe that?

A Well, obviously in the wintertime, particularly in Maine, New Hampshire, and Vermont the weather is so bad that construction almost comes to a halt. When there is nobody working, no employer contributions are coming in, and the cash flow is down to a trickle. In some of the funds that don't have big reserves at a point in time—and that, incidentally, is when most claims are received in our office. You take, for instance, a man who might have a hernia and he wears a truss for six months out of the year, but then he knows he's going to be laid off for two or three months. He decides to go and have that hernia repaired because that's a good time to do it. Not only would he have his hernia taken care of when he's not working, he'll also collect weekly income replacement during that time, which is an added incentive. So most of our claims come at a time of low employment. That's statistically proved over the years. So consequently you would have all your claims at a time when you had no cash flow, no money to pay the claim. Again, that's disaster.

Q Well, does insurance help alleviate that problem? [1-52] A Yes, with insurance you pay your insurance for the next six months; and whether you bring in any money or not the claims are going to get paid; and whether the claims exceed the premiums, they are going to get paid.

Q Did the bricklayers have a deficit at some point?

A Yes, they had a $64,000 deficit last year.

Q And by "deficit" do you mean that the amount paid by the insurance company was approximately $64,000 greater than the premiums?

A That's right.

Q How was that resolved?

A At the present time it hasn't been resolved. This year there was an experience refund of $32,000, and there is still a deficit of a little over $30,000, and the bricklayers are presently considering whether or not to

walk away and leave them holding the bag and possibly go uninsured.

Q Now, what would have happened in the past if the bricklayers had not been insured and had run up that deficit?

A They probably would be bankrupt.

THE COURT: We will take the morning recess.

(Recess.)

[1-53] Q Mr. Dawson, are you familiar with the phrase "mandated benefit clause"?

A Yes, I am.

Q What do you understand that phrase to mean?

A I understand it to mean those benefits which have been mandated by law for a plan to have to have as part of their package.

Q Does New Hampshire have a mandated benefit law?

A Yes, it does.

MR. GREENFIELD: Your Honor, we have a copy of that statute here. With the Court's permission, I will hand it up.

THE COURT: Do you have a copy?

MR. MONTGOMERY: Well, we do have a copy, and it certainly is available to us. We don't have a copy with us.

MR. GREENFIELD: I'm not going to go into the particular details of the statute, your Honor. I think we have an extra copy, in any event.

MR. MONTGOMERY: I would certainly like to see it in case I might inquire with respect to the statute. Thank you.

We have no objection.

THE COURT: Is an offer being made of this [1-54] Counsel? Are you making an offer?

MR. GREENFIELD: I will, your Honor, but it's not really evidence in the strict sense. It's a statute.

THE COURT: We'll mark it for identification.

(Copy of statute, above-referred to, marked Exhibit A for Identification.)

MR. GREENFIELD: Your Honor, as I understand it, that is Section 45:18A.

Q Now, is it part of your duties to be generally familiar with the requirements of that statute?

A Yes, it is.

Q Could you give us your understanding of what that statute requires?

A It requires that nervous disorders and mental conditions that may be helped by short-term therapy in the opinion of a psychiatrist, such as a psychologist, must be paid for on the same basis that other medical benefits are paid for to other professionals.

Q Do you understand if there's—that law or any amendment to that law provides anything with respect to pastoral counselors?

A Yes, that law which originally applied to psychiatrists and psychologists now applies to licensed [1-55] pastoral counselors as well.

Q Now, are you at all familiar with a case known as Wadsworth against Whalen?

A Yes, I am.

Q What is the basis of that familiarity?

A I was one of the participants in that case.

Q Now, did the enactment of the New Hampshire mandated Mental and Nervous Benefits Law have any effect on any of the plans you administer?

A Yes, it did.

Q Would you describe those effects?

A In the case of the Northern New England Carpenters, the Carpenters had to make the very hard decision. They felt they could not afford to pay for the benefits required by that statute and still keep all the benefits they had in their own particular plan. The net result was that they increased the eligibility requirements

from 600 to 750 hours every six months and they eliminated all vision and dental care under their package in order to meet the requirements of the state mental health law in New Hampshire.

Q Now, approximately what had they been paying, what percentage had been paid into the fund with respect to visual and dental care?

[1-56] A Vision and dental care was costing them approximately ten percent of their package.

Q Approximately what would have to be paid into the fund to provide the benefits covered by the New Hampshire mandated benefit law?

A Our insurance consultant estimated they would increase our cost by ten percent.

Q Now, did the enactment of that law have an impact on any of your other funds?

A Yes, it did.

Q Could you describe that?

A Basically it had the same impact on most of the other plans, and it was at that time that many of them went from 600 to 750 or 800 hours. The one that had 400 hours of eligibility went from 400 to 600 hours of eligibility, and there was a very definite—besides a cost, it had an antagonistic result in the plan. The members became antagonistic to me as well as the very fact that they had to have something they didn't want and to give up something they did want. Many of the benefits—most of these funds are in, you might say, a state of flux. They are continually seeking to improve the packages. If they had their way, they would reduce eligibility [1-57] requirements down to a minimum, and they would also increase the maximums on all the coverages. They are continually striving to do this. So there was a period there when they could not only not increase their benefits, as in the case of the Carpenters, they actually had to reduce benefits. Most of the other funds, as I said, increased the rules of eligibility, which, again, is a cost

factor to the members, and it hurts. They were very belligerent and antagonistic and very unhappy about it.

Q Was any unhappiness expressed with respect to the fees charged by psychologists?

A Yes, I had one particular example that stands out in my mind. There were many of them, but this one stood out because the woman was so graphic in her discussion. She came to my office and asked to see me personally, and she said she had a real gripe. She wanted to know why we had, through Lincoln National, had paid $35 for a visit from a psychiatrist, and I said because that's the bill that was submitted to the insurance company. I had gone to the file—as I told you previously, I kept photostatic copies of all bills and all claims—and I showed her the actual bill from the [1-58] psychiatrist of $35 per visit. She was very, very incensed. She said she had been going to this Manchester Mental Health Center for quite some period of time, and prior to this they had been charging—and she was receiving group therapy, not individual treatment, group therapy—she said she had been charged $6 for each visit up until the time that the mental health law was passed. At that time each individual, apparently, judging by her bill, was suddenly charged $35 for each participant in group therapy, and she was highly incensed about it and felt she was cheated.

Q Did the statute have any additional effect upon the Bricklayers Fund?

A Yes, the Bricklayers Fund went to a position where they were technically financially insolvent. I believe at that particular time they dropped down to about $20,000 total assets, which doesn't represent even six months coverage. It might be well to explain a little bit more in detail exactly how this works. As I stated previously, an individual has to work either 600 or 750 hours in a six month period, and there is a two month lag between the time that the man has completed his eligibility [1-59] requirements and when the insurance actually

goes into effect. Because we, in fact, have to get all the employers' reports into our office, put them on computer, tabulate them, send out notices to the employees telling them who is covered and who isn't covered, and so forth. So at any one time there should be eight months of contributions, the six months that have come in plus the two months lag. So at any time there should be eight months reserves just to break even. At that time, as I say, the Bricklayers had about $21,000 in reserves where they should have had at least $60,000 in reserve just to break even.

Q How does this relate to the New Hampshire mandated benefit law?

A We believe that it was the additional expense of that law that caused the fund to go downhill financially.

Q What, if anything, did the Bricklayers do with respect to this problem?

A What they actually did was they went to their employers and asked the employers—because this was in between negotiations they could not negotiate a larger contribution, so what they did was ask the [1-60] employers to take an additional either ten or fifteen cents—at the present time I'm not sure which one—an additional contribution out of their pay envelope and reduce their pay by that amount and put that money into the fund to keep it solvent.

Q Now, in your opinion would the benefit packages that your unions now have be any different today if there were no New Hampshire mandated benefit statute?

A Absolutely.

Q How would they be different?

A Programs that they wanted, some of the programs don't yet have vision and dental. They would like to have them. Others, for instance—

MR. MONTGOMERY: Objection, your Honor.

THE COURT: I'm going to take it, but it may be subject to be stricken. I'll hear the answer. You may go on.

A Some of the members, as I previously explained to you, the plumbers, would have liked $1,000 maximum on their dental, $125 on vision. Most of the plans that have vision, for instance, now would like, at least, because it's not practical to say that you can get a pair of glasses for $75. It's just not [1-61] practical anymore, and that's the type of benefit they would like to have. But by taking money and spending it for mental health care, that precludes at this time the benefits that they would really like to have. They would like to have—most of them have a surgery schedule of the maximum $500. Today I submit a surgery maximum of $500 is no more practical, but there isn't any of them that have a higher schedule than $500. Some of them have board and room, hospital board and room as low as $20 a day, certainly not practical. Obviously, they would like that better, but they can't afford it at this time.

Q Now, as you mentioned it, does the New Hampshire mandated statute apply to employees who reside and work in New Hampshire?

A Yes, it does.

Q Some of the employees in your unions work in all three states; is that correct?

A Yes, they do.

Q And some of them change residences as a function of where they are working?

A Yes, they do.

Q And some of them on occasion, because of the itinerant [1-62] nature of their work and the fact that they might have families, may at one point in time have more than one residence?

A Yes, they do.

Q Or they may be residing, either for that reason or for personal reasons, apart from their wives and children?

A Yes.

Q Now, if you were to administer the fund so as to apply the New Hampshire benefits only to employees who

are residing and working in New Hampshire, would that create any sort of administrative problem?

A It certainly would.

Q Could you describe those problems?

A Yes, as I previously stated—let's use the Carpenters as a good example. The Carpenters, as I believe, are contributing 73 cents an hour into their plan. Now, if they contribute—if John Smith is contributing 73 cents an hour and John Brown is contributing 73 cents an hour and one of them lives in Maine and one lives in New Hampshire, yet they are both contributing to the same plan and their employers are paying the same cents per hour on their behalf and yet one has a coverage that the other one doesn't [1-63] have, and even worse than that, if we were to carry it to its logical conclusion, because the man living in Maine didn't have to have the New Hampshire benefits, he could have greater benefits in another area to compensate for it, you would have actual chaos there, the fact that two people working together at the same bench causes tremendous resentment and real hardship.

Q In administering ERISA plans, is there something known as a plan document?

A Yes, there is.

Q What is a plan document?

A ERISA requires what we call a summary plan description and a plan description to be delivered to every participant. In fact, it is called the plan booklet or the plan document, and it describes in detail, and the law requires it be in language that the individual can understand. That describes the plan and all its benefits.

Q Now, if you were to apply the New Hampshire statute so as to only provide benefits to employees working in and residing in New Hampshire, would that have any effect upon plan documents?

A Yes, because we would have to produce a plan document for each particular state and what benefits

that [1-64] particular state had. Instead of one plan document which would be given to everybody regardless of where he resided, you would have to have a different one for each individual situation.

Q Now, these various things that you have been testifying about for the past few moments, would they have an effect on the administrative costs?

A They have a tremendous impact on cost because just printing new documents is a very expensive procedure.

Q Now, do you, in fact, provide the New Hampshire mandated benefits only to employees who work and reside in New Hampshire?

A No, the trustees, in examining the situation, felt that the cost impact of doing exactly that in providing separate booklets for everybody, and so forth, would be greater than actually providing the uniform benefits for everybody, and they felt that the uniform benefits were so important that they spent the extra money to provide the same benefits for everyone regardless of where they lived and worked.

Q Are you aware of the existence of other mandated mental benefit laws besides New Hampshire?

A Yes, other states have various mandated benefits. [1-65] Q And are you aware of the existence of mandated laws in areas other than mental health?

A Yes, some states require payments for chiropractors, osteopaths, chiropodists, various other benefits.

Q As a professional administrator, are these mandated laws of concern to you?

A They certainly are.

Q And are they of concern to other professional administrators?

A Certainly.

Q What is the reason for that concern?

A Well, in the first place, it goes to the very basics of creating these plans. Plans such as the Carpenters were created in order that you might have uniform

benefits for people who have to work in three different states. At the present time in the Seabrook Power plant in Seabrook, New Hampshire, we have itinerant workers from almost every state in the union. The very fact that all these workers have to work in all these different places was what created such as the Northern New England Carpenters, so the carpenters in Maine, New Hampshire, and Vermont could all work together in the area harmoniously, have one set of plans that would satisfy everybody, [1-68] and reduce administration costs. That's one of the real things of having a plan such as the Northern New England Carpenters. Now, if you're going to create havoc, in my opinion, by having different mandated benefits in all three states, you are going to increase tremendously the administrative costs. You are going to destroy the continuity or the regularity of having one set of benefits for everybody, and it's just chaos for administrators, and we are very concerned about it.

Q Now, in actual practice in your experience, does the New Hampshire mandated benefit law affect plans as such?

A It very definitely does.

Q Could you explain, without repeating anything I just said, how this is so?

A Well, aside from what I already said, it makes them make a very hard decision. Either we are going to have to meet the costs of all these mandated benefits, or we are going to go uninsured, which is the only way to go out of it. There's the gist of the whole thing. Many of them are small plans that cannot afford to go uninsured. They don't have the cash flow. They don't have the resources, and they can't [1-67] afford the benefits. It's a Catch 22 situation. They can't afford the benefits, and they can't afford to avoid them by going uninsured.

Q Do you have any opinion as to what the—aside from the administrative costs—as to what simply the

benefit cost of the New Hampshire mandated statute has been?

A Well, the only way that I have to base my opinion on is the experience of Blue Cross-Blue Shield. Some of our plans previously had Blue Cross-Blue Shield. We are very familiar with their situation, and we know for a fact because it's public knowledge that they had asked Commissioner Whalen for, I believe, a 20 percent rate increase—

THE COURT: 20 or 27?

THE WITNESS: 27 percent rate increase.

A It was rejected by Mr. Whalen. That plan up there is a Vermont, New Hampshire plan. It covers both Vermont and New Hampshire. It's one plan. An investigation proved that Vermont did not need that rate increase. Further investigation proved that it was the opinion of Vermont that the reason they didn't have to have the plan was because they didn't have mandated benefits, where New Hampshire does. [1-68] After considerable discussion between the insurance commissioners of both states it was decided that because Manchester had mandated benefits, which was increasing the costs tremendously—Vermont didn't need those—Vermont would be better off by itself. And as of November 1, according to press releases, Vermont will be separated from New Hampshire as far as their financial structure is concerned. They will have their own rate structure, but they will use the administrative services of New Hampshire, but they will not be involved in the rates or the financial resources of the New Hampshire plan. So they are separating because of mandated benefits.

Q Do you have an opinion as to what the impact on plans would be if Wadsworth is followed and the number of state mandated benefit statutes increases?

A Some of the plans could go bankrupt.

Q Why do you say that?

A Simply because they cannot afford the benefits, and they cannot afford to go uninsured either. If they try to

go uninsured, I think many of them will collapse. They are too small to handle it. They don't have the reserves.

Q Now, as an administrator, have you considered ways [1-69] to reduce or avoid the burdens imposed by mandated benefit statutes?

A Yes, we considered going uninsured.

Q Would you have any reason to go uninsured other than to avoid the mandated benefits—benefits mandated by such statutes?

A No.

Q What alternatives do the small plans have on the mandated benefit statutes?

A I don't think they have any alternatives.

Q With respect to the functions that they play, is the there any difference between an insured plan and a non-insured plan?

A No, there isn't.

Q Based on your experience, can you conceive of any possible reason for treating the two types of plans differently with respect to the application of state mandated benefit laws?

A No, I cannot.

* * * *

[1-72]

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Dawson, are any of the eight plans that you administer insured either through Metropolitan or Travelers?

A No.

Q With respect to the New Hampshire statute that you discussed on direct examination, I think that you testified that it requires that benefits be provided for mental or nervous conditions to the same extent as for other illnesses; is that correct?

A Correct.

Q Is there a limit on the recovery of a claimant under this statute?

A I believe it's $10,000.

Q Are you familiar with the Massachusetts statute which is the subject of this proceeding?

A No, I'm not.

Q With respect to the coverage that's afforded on mental and nervous conditions through the plans that you do administer, are the coverages for mental and [1-73] nervous conditions standard for each plan?

A Yes, there are.

Q How many insurance companies do you use through the plans?

A Just one.

Q And is there a standard co-insurance provision that applies to the mental and nervous condition coverage?

A Under major medical?

Q Yes.

A Yes, 20 percent.

Q And is that same 20 percent co-insurance provision applied to all other major medical benefits?

A Yes.

Q Is there any deductible on your plans?

A Yes.

Q What's the deductible?

A $50 as far as the Carpenters are concerned. The Masons are $100.

Q On direct examination you testified with respect to your experience in meetings with union representatives in New Hampshire and Maine and Vermont, and that your role at these meetings has been to inform them with respect to the types of insurance coverage that is available; is that correct?

[1-74] A Yes.

Q And presumably you do inform them with respect to the mandated benefits that restrict the choices that they might make?

A Yes, I do.

Q Now, in addition to various statutes which require payments to certain types of practitioners, isn't it true that there are other types of mandated benefits?

A Such as?

Q For instance—and you would be more familiar than I—does New Hampshire, Maine, or Vermont mandate conversion benefits?

A Yes, they do.

Q Could you please define your understanding of conversion benefits?

A If an individual is covered by one of our policies and he loses his eligibility, we have to provide him with the opportunity to convert that policy to an individual policy within a certain given number of days after his regular policy expires.

Q And are the conversion benefit statutes in New Hampshire, Maine, and Vermont identical?

A I don't believe they are.

[1-75] Q They do differ to some extent?

A That's right.

Q I believe you testified you played a role in the case of Wadsworth versus Whalen. You said you were a participant. In fact, you were a plaintiff, one of the plaintiffs in that case?

A Yes, I was.

Q Have you ever been a plaintiff in any other case challenging a mandated benefit statute?

A No, I have not.

Q So that you haven't challenged any of these other types of mandated benefit statutes?

A No, I haven't.

Q In addition to conversion benefits, were there any other examples that you can think of that require coverages in the states of New Hampshire and Maine and Vermont?

A I don't think of any offhand.

Q How about waiting periods? Are there any requirements on waiting periods?

A Actually none of those apply to our plans because a participant becomes covered immediately as soon as he's got the required number of hours in. So it doesn't impact on our plans at all.

[1-76] Q Is your answer, by implication, yes, there are statutes in those states?

A Yes, there are.

Q And do you know specifically what those statutes say?

A No, I don't.

Q But the benefits of your plans are more liberal than the required mandated benefits?

A Yes, they are.

Q Now, do any of the plans that you administer provide benefits to employees who are residents of the Commonwealth of Masachusetts?

A It's very possible, very possible. I'm sure there are. Let me explain. I'm not positive how many residents of Massachusetts there are because as I previously explained the itinerant workers oftentimes move into an area and stay there. Construction workers will hire a trailer between them.

Q Let me restate my question. Are any of the employers who contribute to the plans that you administer residents of the Commonwealth of Massachusetts?

A Yes, they are.

Q Could you identify the names of some of those employers?

A Volpe, Grande Brothers, to name a couple.

[1-77] Q Now, do those employers contribute to your plan with respect to services provided by members of the plan in Massachusetts?

A No.

Q So only the—the contributions only apply to work that is performed in the three states, New Hampshire, Maine, and Vermont?

A That's right.

Q So the administration of your plan is confined exclusively to those three states?

A Yes, it is.

Q Returning again to your role in collective bargaining. I think you have sometimes in your direct examination referred to negotiated plans.

A Yes.

Q Isn't it true, Mr. Dawson, that some plans negotiate the particular benefit while other plans negotiate the level of contribution by employers to the plan?

A I can only speak for the plans that I administer and in each case while the contract that is finally negotiated specifies a cents per hour, that cents per hour is determined by the cost of the benefit that the individuals wanted. So an individual might say that "I want vision and dental now," and I tell [1-78] them it's going to cost ten cents an hour to get it. The contract actually says ten cents an hour, but that ten cents an hour is the dime to pay for the vision and dental that they just negotiated.

Q Do you agree that what the employer has agreed to contribute is a level, a particular amount per hour, for the services, in connection with the services of a particular employee?

A Yes, he agrees to cents per hour based on whatever they agree to furnish.

Q Therefore, the collective bargaining agreement itself contains nothing about particular benefits?

A That is correct.

Q But it's been your information provided to the union with respect to available benefits that has determined the level that they have demanded from the employer?

A That's correct.

* * * *

[1-81] Q Have you ever administered an uninsured plan?

A No, I haven't.

Q Would it be fair to say that if you ever did administer such a plan that it would be likely that such a plan would contain some saving provision that would prohibit or avoid any payment over claims—I mean, any claim payments over the level of contributions to the plan?

A It's possible.

Q Well, I mean, obviously it seems to me that you wouldn't have the money to pay claims in excess of payments, correct?

A I would recommend that to the trustees.

Q What do you mean by recommend to the trustees? What process—if you receive claims in excess of receipts or pay-ins to the plan, what procedure would you then follow?

A I would go to the trustees—if it was uninsured?

[1-82] Q Uninsured.

A I would go to the trustees and tell them that we were in a deficit position, we couldn't pay our bills, and they would make a decision whether they wanted to go out and borrow money or declare themselves bankrupt.

Q You also testified with respect to a cyclical experience in your practice and your business in New Hampshire, and I was a little bit puzzled by your testimony. You said that an uninsured plan would have difficulty paying claims during the winter months because you have a reduced cash flow. Is that a fair summary?

A That's correct.

Q I'm a little puzzled by that. If you were going to run a self-insured plan, wouldn't you establish provisions through reserves, and wouldn't you be adequately capitalized to avoid that particular problem?

A I would certainly recommend that the trustees do that, but I have no guarantee that they would do that. In fact, experience has proved that in the case of the carpenters or the bricklayers, specifically, they had huge deficits that would have, had they not [1-83] had insurance and the insurance carried them for the deficits, they

would have been bankrupt. So in point of actual experience, the trustees don't exercise those constraints.

Q Well, of course, because you use the insurance mechanism the trustees don't have to exercise those constraints; isn't that true?

A That's right, but that's the only thing I have to go by.

Q So you really have no experience that would shed any light on what would occur if the plans were self-insured?

A Only the experience of what has happened while they were insured.

Q But presumably if they were self-insured, at least by your testimony, the benefits would differ. Isn't that a fair assumption?

A It could be.

Q And if the benefits differed, presumably the costs would differ? Is that also a fair assumption?

A That's correct.

Q Now, previous to the enactment of the New Hampshire mandated benefit law, did the plans that you administer provide any benefits for treatment of mental or [1-84] nervous conditions?

A Yes, they did.

Q And have you done or had any studies performed or compiled any data that would reveal the difference in expenditures under the plans as they existed prior to the enactment of that statute and then subsequent to the enactment of the statute, with respect to that particular benefit?

A There were no actual studies done other than to compare the fact of what the limits were before and what they were afterwards.

Q Now, in your direct testimony you indicated that the cost—that you were estimating the cost impact of this statute from Blue Cross-Blue Shield?

A That's right.

Q Can I take it from your answer that you don't have any specific cost data from your experience with Lincoln National?

A Only as I said the increases in what we were providing as a payment to psychiatrists and psychologists and what the law mandated we had to pay them and what we actually did.

Q What do you mean by that?

A We were paying $10 a visit. That was the maximum. [1-85] Our policy provided we would not pay more than $10 a visit. By law we began paying $35 to $50 a visit.

Q With no limit on the amount that you have to pay up to $10,000?

A Yes, up to $10,000, right.

Q I'm a little puzzled. You mean you don't have information from Lincoln National of your experience of the total payout to psychologists and psychiatrists?

A They do not break it down because nervous conditions can be—let me give you a typical example. A woman at the time of menopause has a lot of nervous disorders. Many of the claims originate at that period of time. Is the root cause physical condition other than mental or nervous? Her doctor might indicate that it was other than mental, and yet she is being treated by a psychiatrist. So the claims data that we get does not indicate that. Therefore, we cannot, the way we handle claims, actually put our finger on that. So our figures came from our insurance consultant who gave us the estimates of what it would cost us.

Q So that to sum it up, there isn't from your personal experience or the experience of the plans you [1-86] administer any data base that's available to draw any conclusions about the impact of the statute?

MR. GREENFIELD: Objection. I don't think he's fairly summarized what his testimony is.

MR. MONTGOMERY: I asked the witness whether I fairly summarized the testimony.

A Well, as I said, the difference is $10 a visit as opposed to $35 to $50 a visit. That's some impact in my opinion.

Q But there is no data base?

A That's right.

* * * *

[1-86] Q Mr. Dawson, with respect to your testimony on direct concerning the cyclical nature of the claims experience in New Hampshire, I believe that just before the lunch break I asked you to explain your testimony that because of cash flow problems it would be difficult in an uninsured plan to make payments in light of this cyclical claims experience?

A Yes, I was referring to those funds who did not have large enough reserves to carry them over in a time of cash flow problems.

Q But, in general most plans, in order to function, have to, like insurance companies, maintain some level of reserves in order to function at all, correct?

A They should, but unfortunately they do not.

Q You mean the plans or the insurance companies?

A The plans do not maintain the reserves they should.

Q I think you previously testified that you didn't have any experience with self-insured plans?

A That's correct. But what I'm saying is that those insured plans just maintain enough money to pay the [1-89] premium when it comes due. They don't have any reserves. As I thought I explained, if an individual has worked six months, he has prepaid his insurance. And there is a two-month lag, so an insurance company to just break even has to have eight months in reserves even when they are insured, and many of them don't have that amount of money.

Q Mr. Dawson, correct me if I'm wrong, but I think you testified on direct with respect to the importance to cover members of plans, of the level of benefits provided, for instance, for surgery?

A Yes.

Q I think you specifically mentioned surgery, and that the general level is $500 per procedure in the plans you administer, right?

A Yes, I did. That's correct.

Q And of course the level of benefit coverage would also be important with respect to the coverage of mental and nervous conditions, right?

A Yes, it would.

Q And you also agree, wouldn't you, that the level of coverage is an important, if not the crucial—

THE COURT: Level of coverage or benefit?

MR. MONTGOMERY: Level of benefits; excuse me.

[1-90] Q —is a crucial determinant of the total cost of the plan?

A Yes, it is.

Q And would you agree that the difference—that the cost of New Hampshire plans would be substantially affected if they were reduced, if the New Hampshire legislature were to reduce the total available benefit for mental health coverage from, let's say, a hypothetical $10,000 to $5,000?

A Yes, that would help.

Q That would have an effect?

A Yes, it would.

Q Now, if the New Hampshire legislature would reduce the total benefit from $10,000 to $500 per year, would that also have an effect?

A Yes, it would.

Q And would you believe that that effect would be substantial?

A Yes, I do.

* * * *

[1-92] Are you familiar, Mr. Dawson, with the concept of what is called in health insurance circles "utilization controls"?

A Yes, I am.

Q Could you explain what utilization controls in general are?

A Well, basically it's an attempt to control the use of any particular coverage.

Q Can you give examples of utilization controls in any particular area of health insurance?

A I don't think so.

Q Are you familiar, for instance, with peer review of procedures?

A Yes, I am.

Q Could you explain what peer review procedures are?

A Well, what happens is that if—well, for instance, in the case of our dental program, a dental bill is submitted. If either the fund office or the employee questions it, that bill is submitted to a group of dentists who are the peers of those charging the thing, and they review the thing to see whether [1-93] or not it's reasonable, and they can knock the bill down , if necessary.

Q Are there any particular utilization control procedures that have implemented by any of the plans that you administer?

A Yes, the vision and dental both have peer review boards.

Q Are there any other utilization controls?

A The dentists have to file a fee profile showing exactly what their charges will be, and every claim is compared to the fee profile when the dentist makes a claim.

Q With respect to benefits for mental and nervous conditions, are there any utilization controls that have been implemented by any of the plans?

A Not to my knowledge.

* * * *

[1-95] Q Are you aware of any plans, employee plans, in the State of Vermont that are uninsured?

A I am not aware of any.

Q Are you aware of any in the State of Maine that are uninsured?

A I am not aware of any.

* * * *

REDIRECT EXAMINATION
BY MR. GREENFIELD:

[1-97] Q Now, when negotiations take place between the unions that you represent and the employers are specific benefits discussed?

A Very definitely there are.

Q And are the costs of specific benefits discussed?

[1-98] A Yes, they are.

Q And is there a give and take and tradeoffs with respect to specific benefits?

A Yes, there is.

Q And are there compromises with respect to specific benefits?

A Yes, there is.

Q Now, if an insured plan incurs a deficit of $100,000, for example, and does not walk away from the insurer, is that deficit recovered in the subsequent year?

A No.

Q Over how long a period is it recovering?

A It's negotiated usually three to five years.

Q What happened with respect to the Carpenters when they had a deficit of $325,000?

A They negotiated with Lincoln National that any refund in subsequent years would go 50 percent back to the fund and 50 percent to write off the deficit until it was paid.

Q And how long did it take to pay off what deficit?

A I believe it took about three or four years.

* * * *

TESTIMONY OF JOHN D. MORRIS

DIRECT EXAMINATION
BY MR. GREENFIELD:

[1-99] Q What is your name?

A John D. Morris.

Q And your home address?

A 93 Tersama Drive, Easton, Connecticut.

Q And what is your present employment?

A I work for General Electric Company. My title is [1-100] consultant, insurance benefits and payroll practices.

Q And where is your place of employment?

A Fairfield, Connecticut.

Q Could you describe your responsibilities to General Electric?

A My job in insurance, basically, involves the financial aspects of our insured plans, which would involve negotiations with our carriers on rates, contract amendments, plan changes, and the like.

Q In the course of your duties do you conduct negotiations with those insurers who handle General Electric's business?

A I do.

Q About what subjects do you negotiate?

A Premium rates, financial arrangements, implementation of benefit changes, and the like.

Q Now, within the General Electric hierarchy where do you fit in with respect to responsibilities for insurance benefits?

A With an associate in employee relations, the two of us do the job.

Q Are you the two most senior people in that area?

A Yes.

Q Could you trace your educational background?

[1-101] A I attended Cornell University. I have a bachelor's degree in economics and a master's degree in business administration with a concentration in accounting. I received the latter degree in 1949.

Q Are you a member of any professional societies or similar organization?

A Yes.

Q And what are those memberships?

A Well, I am a member of the Financial Executives Institute, Committee on Employee Benefits, and a subcommittee on insured benefits.

Q Have you participated in the Business Round Table?

A Yes, I have.

Q Would you describe that participation?

A The Business Round Table created a committee on privacy in the workplace for employees. I served on that committee. We held a series of seminars around the country last year which were attended by in excess of 600 executives from Business Round Table and other companies.

Q Have you ever given testimony before any federal commission?

A Yes, I have.

Q Would you describe that?

[1-102] A I testified before the Federal Privacy Study Commission in connection with confidentiality of employee records. I subsequently testified before a Department of Labor hearing on workplace privacy.

Q Now, does General Electric provide health benefits for its employees?

A Yes.

Q Does it have a group of benefit plans?

A Yes, it does.

Q Approximately how many plans does General Electric have?

A I expect we probably have 20 plans.

Q And do these include something known as the General Electric Insurance Plan?

A Yes, it does.

Q And from where is that plan administered?

A It is administered in Fairfield, Connecticut. Under ERISA, General Electric is the plan administrator.

MR. GREENFIELD: Your Honor, I would like to put into evidence two documents that have been previously marked. Exhibit 1 is a publication entitled "General Electric Employee Benefit Plan Document." Exhibit 2 is a publication entitled "General Electric Employee Benefits, Summary Plan [1-103] Description," and I move them into evidence.

THE COURT: May I take a look at them, please? I assume these are without objection?

MR. MONTGOMERY: No objection.

(Two General Electric documents, above-referred to, marked Exhibit Nos. 1 and 2.)

Q Could you explain what Exhibits 1 and 2 are?

A Exhibit 1 is a document that contains the official text of specified benefit plans. Beginning on page 1 and continuing through page 25 is the General Electric insurance plan, the official text and the supplements. Exhibit 2 is a summary plan description of exactly the same plans contained in Exhibit 1. The summary plan descriptions are required by ERISA. They are supposed to contain a statement of the plan couched in language understandable by the ordinary person. We are required by ERISA to provide the summary plan description, but we historically have and continue to provide employees with the official text of the plan.

Q Now, both Exhibit 1 and Exhibit 2 say on their covers that they are for non-exempt salary employees. Do other employees receive—do other regular employees receive the same benefits as are described on [1-104] Exhibits 1 and 2?

A We have three categories of employees, exempt employees—this is under the Wage, Hour and Fair Labor Standards Act—non-exempt salary employees, and hourly employees. As far as the General Electric insurance plan is concerned they are identical in all three plan booklets.

Q By "identical" do you mean that they receive the same health insurance benefits?

A Exactly.

Q Does the president receive the same benefits as a sweeper does?

A Absolutely, the Chairman of the Board has exactly the same health benefits as the lowest paid hourly employee.

Q And do the health benefits depends upon what state you are in?

A No, we have uniform benefits in the health area.

Q Now, how many covered employees are there under the insurance plan?

A At last count we had 274,000 employees plus 8,000 in our Credit Corporation, which is 282,000. In addition, we had about 13,000 employees who are not actively at work, absent because of illness, layoff, [1-105] leave of absence, whose coverage was continued under the plan. In addition, we have some 17,000 pensioners under age 65 who continue to have the same health benefits as provided in the booklet. So altogether that's about 312,000 employees and pensioners.

Q Now, does the plan provide benefits for dependent coverage?

A Employees covered by the plan may enroll for dependent coverage.

Q How is that financed?

A They pay up to a maximum of $100 a year for dependent coverage. If I may add, the coverage is exactly the same as the coverage as it applies to each employee.

Q How many dependents are covered?

A Let me try it the other way, please. About 70 percent of our employees and pensioners have dependent coverage. So that means 220,000 employees have dependent coverage. Our insurance company's actuaries advise us that there are probably two and a half dependents per dependent unit. So that comes up to 600,000 or 700,000 dependents.

Q Now, does—and so all together about a million people are covered by the plan?

A About a million people; that's correct.

[1-106] Q Does General Electric engage in collective bargaining negotiation with any unions?

A Yes.

Q Is there any relationship between those negotiations and the benefits specified in Exhibits 1 and 2?

A There is.

Q Would you describe that realtionship?

A Well, we enter into collective bargaining, and the result is that we end up with benefit plans that have been collectively bargained.

Q Are specific benefits bargained?

A Yes.

Q Do you play any role in the collective bargaining process?

A I do.

Q Could you describe that role?

A My principal role is a support role in helping to prepare cost estimates and other data required for the negotiations, subsequently reducing these, with the cooperation of the insurance company, to plan language and eventually into summary plan description language.

Q Now, in performing these duties do you conduct any studies or do any surveys?

[1-107] A Our company does, yes.

Q Could you describe them?

A There are several kinds. First, we have our employee relation staff visit plant locations where there are not collective bargained units and discuss with employees and management what the employees feel are their needs in the benefit area. We also hire outside consulting firms to make surveys of our employees and pensioners to obtain information of their interest in terms of benefits. We also conduct surveys of our peer companies as well as the companies that are in competitive areas to determine benefits.

Q And certain priorities are determined as to what the workers want and what they don't want?

A That is correct.

Q Does the union do anything of a similar nature?

A Yes.

Q Would you describe that?

A The exact process I don't know. However, they do talk to their workers, and then periodically in their plant newspapers and other organs will publish the results of their discussions with their members in terms of what the members of the collective bargaining [1-108] unit want.

Q And that is again in terms of priorities?

A Yes.

Q Do you attend some collective bargaining sessions?

A Yes.

MR. GREENFIELD: Now, I would like to offer this into evidence as Exhibit 3. The Commonwealth has consented to its admission. This is a document which the witness will further describe which is entitled "Health Insurance," and it bears in the upper left-hand corner IUE-AFL-CIO-CLC, May 16, 1979.

(Document, above-referred to, marked Exhibit No. 3.)

Q Could you tell the Court what Exhibit 3 is?

A Exhibit 3 is a list of demands in the health insurance area that was presented by the union during bargaining in New York on the date shown.

Q Which union?

A The IUE-AFL-CIO.

Q What role do they play in the bargaining with respect to benefits?

A We bargain nationally with the IUE, and this was the demand they presented. However, we have something called coalition bargaining. What this is is that [1-109] the IUE officially sits at the table, but immediately behind them are representatives of other unions that are in the AFL-CIO, such as the IBEW and the like. So they are present at the table, although technically we do not bargain nationally with the IAM, the IBEW, steel workers, and the auto workers.

Q Now, did you receive a copy of Exhibit 3 in or about May of 1969?

A I did.

Q And what did you do with it?

A I carefully reviewed it, sir, to see which of the items—what was on the list and how many of these I had already prepared cost estimates for. For those that I had not prepared cost estimates, I immediately did so.

Q And did Exhibit 3 play any role during the collective bargaining negotiations?

A It did.

Q Would you describe that role?

A Well, each of the demands was, of course, evaluated and presumably discussed at the table. Some of them did, in fact, were, in fact, included in the settlement agreement. Others were not.

Q Well, why don't you go through items one to five on [1-110] Exhibit 3 and state how they were resolved during the collective bargaining negotiations?

A Yes, sir. Item one, which was 100 percent payment of medical expenses after an employee was out of pocket $1,000 for the employee and family, was, in fact, included in the final settlement and appears in our benefit booklet. Item two, which states eliminate major medical maximum amount—I'll take these one at a time, if I may. Prior to the negotiations we had a lifetime maximum of $250,000 per covered individual. In the negotiation this was incraesed to $350,000. So we didn't eliminate it, but we did increase it to $350,000. Cover all expenses including surgical centers we did include in the contract settlement coverage for ambulatory surgical centers. Nursing homes is the next item. That's sort of an undefined term, but in the contract you will see that we provided for extended care facilities for up to a maximum of 120 days. Recovery facilities, I think we had already covered those in the sense that recovery rooms and the like are in a hospital. On replacement of necessary or required prosthetic appliances, this did not appear in the final settlement.

[1-111] Q That item was rejected then?

A Yes. Well, it didn't appear, so it didn't get through, right.

On item three, relating to mental and nervous disorders to be paid the same as any illness, including alcohol and drug rehabilitation treatment, well, in 1976 we had included in the settlement as the result of a demand coverage for licensed detoxification centers. With respect to the last item, treatment by a licensed social worker, it is not in the final settlement.

Q That was considered and rejected?

A That is correct. Item four was to reduce the family deductible to $100. Prior to negotiations it was $125, and no change was made in that item. On item five, provide complete company payment for insurance for employees and dependents and retirees and dependents for Medicare, Part B. Employee insurance is non-contributory. Insurance for dependents, as I indicated earlier, is $100 a year, and those two were left unchanged. With respect to retirees and Medicare, we did not provide a benefit. However, for employees working past age 65 who are enrolled for Medicare, Part B, the company does reimburse them for the [1-112] Medicare B premium.

MR. GREENFIELD: I would like to offer into evidence without the objection of the Commonwealth Exhibit 4—

MR. MONTGOMERY: No objection.

MR. GREENFIELD:—which is the index to the 1979 settlement agreement between General Electric Company and the International Union of Electrical Radio and Machine Workers, AFL-CIO. Attached to that is Part Two, which is the pension and insurance agreement between General Electric and the International Union of Electrical Radio and Machine Workers.

THE COURT: May I see it.

(Document, above-referred to, marked Exhibit No. 4.)

Q Could you explain to the Court what Exhibit 4 is?

A Yes, Exhibit 4 of the index is actually a summary of the actual signed contract between General Electric and the IUE. As you can see, particularly looking down into the area of Index Tab B, Part Two, there is a separate pension and insurance agreement, and appended to that separate insurance and pension agreement are the texts of the benefit plans as negotiated.

[1-113] Q Would you refer to page 2, which is, in fact, the fourth page of this exhibit, page 2 of the agree-

ment itself, and would you just read in the record the Section 2B?

A Section 2B: "Subject to the approval of the company's Board of Directors and subject to provisions of this Section 2 and Section 1 of Title 2 hereof, the company, the union, and the locals hereby agree that the benefits outlined in the July, 1979, insurance plan shall be made available to the employees in place of the April, 1979, insurance plan as of July 1, 1979."

MR. GREENFIELD: Now, I'd like to move into evidence without objection from the Commonwealth Exhibit 5.

(Document, above-referred to, marked Exhibit No. 5.)

Q Could you tell the Court what Exhibit 5 is?

A Exhibit 5 is, looking back to the index on Exhibit 4, is Tab F, Exhibit D, which would be the General Electric Insurance plan that actually is incorporated in the union settlement agreement.

Q That's the one referred to in the paragraph you just read?

[1-114] A That is correct, and what it is is taking the plan as it was and showing the changes that were made as the result of the negotiations. These are marked with sort of a black tape on the edge of the page.

Q Is it fair to say, then, with respect to Exhibit 5, that where information is typed in as opposed to being printed, that that is what was agreed to during collective bargaining negotiations?

A Yes.

* * * *

[1-120] Q Now, the benefits that are set forth in Exhibit 5, are they the same in every local pay unit?

A They are.

[1-121] Q And are they the same throughout the country?

A Medical benefits are the same throughout the country.

Q And they apply to both union and non-union employees?

A That is correct.

Q What is your reason for doing it in this way?

A Well, we have a long history of uniform benefits in this area. Starting back in 1920 we had group insurance. In the early '50s we got into medical insurance on a nationwide basis for our employees, in 1955, for dependents. But they have been uniform benefits in the medical area since square one.

Q What are your reasons for seeking uniformity?

A Well, there are several reasons. From a cost point of view, it is much more efficient to have one benefit structure. It costs less money to administer. It certainly is much easier to communicate if you have only one plan to communicate. It seems to work very well in our collective bargaining situation. Our unions seem to be satisfied to have one benefit structure that applies to all unions as well without having variations, and certainly from overall employee relations point of view there are not these concerns that employee A has benefit structure A and employee B has a different benefit structure. So it's just [1-122] been the way we have operated and found it to work very well. Uniformity has been, I think, very important in our structure.

Q Is there any relationship between the size of the benefit package and administrative costs?

A Would you repeat that, please?

Q Well, is there any relationship between the amount of benefits given by General Electric and the cost of administering benefit programs?

A Well, we have one benefit structure, and we incur the administrative cost to handle that particular structure, whereas if we had ten structures, it would be more difficult administratively, and it would cost more to administer.

Q And would that affect the amount of benefits

A Well, I think it has to, yes.

Q Could you explain why?

A Well, I believe there is total compensation that is going to be paid to an employee. It's going to be a mixture of benefits; it's going to be a mixture of pay. If you increase the administrative costs, then there is going to be something less for something else in a future time.

THE COURT: I just didn't get that, I'm sorry [1-123] to interrupt you. I didn't quite catch your explanation. Would you go through that again?

THE WITNESS: I would be glad to, your Honor. I'm starting on the assumption or the belief that there is a compensation package total which is worth some dollar amount. It's usually a mixture of benefits, the cost of benefits plus the direct compensation. Now, if for some reason the cost of the benefits is increased because of administrative costs that go up or you do something else, then there is less for something else. Now you may be struck until the next negotiations, but you would take that into account in doing future increases.

Q Is it fair to say that there is something like a finite piece of pie?

A Yes.

Q And the more you spend on administrative the less there is for something else?

A Yes.

Q And the more you spend for one benefit the less there is for another benefit?

A Yes.

* * * *

[1-132] Q Mr. Morris, before the recess you were giving some of your reasons for recommending local pay. Are there any other factors that led you to make that recommendation?

A Well, yes.

Q What were they?

[1-133] A Well, we had a uniform benefit system, and it became very logical to do this with that uniform system in place.

Q Now, did management agree with your view of the merits of the local pay system?

A Yes, they did.

Q And it was your recommendation that was followed?

A That is correct.

Q Now, would the course and efficiency of the local pay system that General Electric has be affected if benefits were not uniform?

A Yes, it would.

Q Could you describe that effect?

A It would have to increase the administrative costs.

Q Do your duties require you to be generally familiar with the term "state mandated benefit laws"?

A Yes.

Q And are you familiar with these laws?

A Yes.

Q What do you understand the term to mean, state mandated benefit laws?

A Well, state mandated benefit laws can take several forms. One would be where, for example, a state law might say if you provide services for a physician [1-134] who renders a particular kind of service, then if it's rendered by a chiropractor, you must provide benefits. Another form of mandated benefit laws would be one that says that you must provide coverage for certain types of individuals in specified dollar amounts or in specified rates.

Q And some deal with specific conditions?

A Yes.

Q And some require certain parity between benefits for one type of care and benefits for another type of care?

A That is correct.

Q And do the coverage of these laws sometime depend upon the residence of the employee?

A Yes.

Q And sometime depend upon where the employee works?

A Yes.

Q And would they sometimes require that the employee both reside and work in a particular state?

A Yes.

Q Now, would mandated health benefit laws have any impact upon the General Electric plan?

A Yes.

Q What would that impact be?

[1-135] A Well, it would completely change the way that we administer our benefits. In other words, let's assume that one of the laws says residence. Then we are now going to have to get information concerning residence status of any claimant, including the dependents. This we don't ned to know at the present time.

Q Well, wouldn't the dependent live with the employee?

A Not necessarily.

Q Could you give some examples?

A Well, you can have divorce situations. You can have children away at college. There are many circumstances where the family is not together necessarily or either temporarily or on a more permanent basis.

Q Would you go ahead and describe other impacts that mandated health benefit laws would have on company plans?

A Well, with our employees all over, where they work and where they reside are not necessarily in the same jurisdiction. So this is bound to cause certain degrees of difficulty, not only administratively, but in the employee relations area. For example, if it says it applies to residents of the state and we have two employees working side by side, one of [1-136] whom is a resident of a state that has a mandated benefit and another one who is not, they have different benefits, and this can certainly create employee relation problems.

Q Does General Electric have facilities close to state borders?

A A significant number of them.

Q Can you give examples?

A Well, let's take New Hampshire. We have a plant in Somersworth, New Hampshire. You can stand in the parking lot and throw a stone into Maine just across a stream. We have a major facility in Cincinnati, Ohio, and I know for a fact a number of employees that work in that facility reside in Kentucky. It's indicated in Exhibit 6, if you look at Louisville, Kentucky, we have almost 20,000 employees in major appliance, and some of them live across the river. So we have—well, even in Massachusetts, I know that some of the employees who work in Pittsfield, in fact, live in New York State because we recently had to offer an HMO to them.

Q Are there any facilities located in New York State near the Massachusetts border?

[1-137] A Yes, there are facilities. We have Selkirk, New York, that's fairly close to Massachusetts. We have Waterford. I wouldn't be surprised at all if some of the employees in Schenectady, do, in fact, live in Massachusetts.

Q With respect to the uniformity of the General Electric plans, would mandated health benefits have any impact on them?

A On uniformity? Oh, yes, it definitely would change.

Q In what way?

A Well, if there are mandated benefits and you have to provide them, then you are going to have a series of different benefit arrangements depending upon the mandated benefits that have been enacted, and this could cause a lot of problems. Assume, for the sake of discussion, that we are talking about a Massachusetts employee with a family, and the social worker, as I understand it, applies to Massachusetts residents. Let's assume for the sake of discussion that marital discord happens;

there is a divorce; the spouse who remains in Massachusetts has the children; our employee is transferred to California. Now, clearly the children still are eligible dependents under the terms of the General Electric [1-138] insurance plan, and probably the divorce decree would require that our employee would provide medical coverage for the dependent, the dependent children. So they are in Massachusetts, presumably subject to the Massachusetts social worker statute, but here our employee is in California. Again, looking at it in terms of our local pay operations, with these possibilities plus transfers plus college and other things, everyone of our 23 local pays would have to adapt to all these mandated benefits.

Q Would the mandated health benefit laws have any impact on the choice of benefits that are made by workers and that are negotiated during the collective bargaining process?

A Yes.

Q Would you give an example?

A Well, social workers were discussed in the last negotiation. They were a specific union demand. The final settlement did not contain that, and this must represent the conclusion of collective bargaining. Now, if there are mandated benefits, it's changing what was negotiated at the table.

Q Where does the cost of that come from?

A Well, it's got to come out of the total somewhere.

[1-139] Q Would the mandated benefit health laws have any impact upon employee morale?

A I think the answer is yes.

Q Could you explain that?

A Well, we can have workers side by side with a different benefit package, or we can have situations where the dependents of one employee get one set of benefits and the dependents of another employee don't have those same benefits because of, perhaps, residence.

Q Now, you testified before about the guidelines and the cookbook. Is there right now one set of guidelines or one cookbook for the entire country?

A Yes.

Q Would the mandated benefit laws have any effect upon that?

A Oh, absolutely.

Q Would you explain that?

A Well, if I could, I would like to explain it in two pieces to try to see what is happening. At the present time we really have four calculation procedures in our system. We have to have a calculation procedure for the A1 that is 100 percent, and this would take care of our $1,000 out-of-pocket [1-140] and our second search. Then we have the A2 calculation field which says, okay, $500 in full and then 85 percent. So that's number two. Number three is the Type B, excluding the outpatient psychiatric, which has the deductibles and 85 percent. Finally, we have a fourth trail, if you want to look at it that way, where we are calculating on the 50 percent basis for outpatient psychiatric. So we have four.

Along comes the state and puts in a mandated benefit of some kind. It means we are going to have another trail. Then another state comes along with another set of requirements, and so far the mandated benefits I've seen are different. So that means another computation trail. So instead of having four, if we go to the extreme of saying that every state is going to have one, we are going to have a separate calculation system to determine benefits properly for each of these states, plus our standard.

So now instead of having four calculation trails, we could have as many as 54 calculation trails.

Now, to continue, if I may. Our carrier is going to have to give us the guidelines or the rules that apply in using these benefits under these state mandated benefits. So they are going to have [1-141] to make a determination of how and to what extent do these apply. Now, I

can see that this could get pretty complicated. For example, one state says it applies to employees and residents, and another state it applies to employees, and another one says residents. So now let's assume that the employee resides in state A that says residents, but he works in state B which says employees, and the benefits are different. Which kind of benefits do we give him? I guess there's an answer, but it complicates the thing.

I can go one step further in that some of our employees have jobs that require them to work in a number of states, for example, sales jobs. Perhaps there could even be someone here in Massachusetts that has as his assignment calling on customers in Massachusetts as well as Vermont, New Hampshire, and Maine. If we have four different benefit laws and they relate to employment, how are you going to determine which apply? Now, I'm not saying that it's insolvable, but it's sure adds to complications and completely destroys our uniform benefit structure.

Q What will you have to do with the cookbook?

[1-142] A It would grow substantially to cover all of this. Now, it doesn't stop there because in order to get the information necessary to process claims—assuming this plethora of mandated benefit laws—we are going to have to change the claim form. We are going to have to ask additional questions presumably broad enough so that we can cover all of these different variations. First of all, employees have a little reluctance in supplying information. This concept of privacy seems to be rearing its head more and more when employees don't wait to supply information. Then if you have added ten more questions, presumably in the claim processing cycle, you have got to examine and review ten more questions, which, again, offers the chance for more mistakes, both on the part of the employee and on the part of our claims processor, since there are more. The logic of getting the answers into the system—we are going to have to do this by computer in a larger operations. There is no

way around it—creates the opportunity for more errors in input data.

Q Would you look again at Exhibit 2, which is the General Electric Summary Plan Description?

[1-143] A Yes.

Q I think you testified that ERISA requires you to put out a description in language that the ordinary employee can understand?

A Yes.

Q How would mandated benefit laws affect publications such as Exhibit 2?

A Well, we would have to expand the summary plan description to cover each state mandated benefit. I agree, we printed a lot of these, but the cost of each page of this document is $6,000. So if we had 50 more pages to put in because of mandated benefits—maybe we could do it with less than 50—that's a lot of additional expense. I would add one more thing. It seems that the laws keep changing, and so we would have to be alert to any change in mandated benefits as they occur, and this, in itself, would create problems because an employee can incur an expense before a change in the law and another expense incurred later, one would think he would get the new benefit, where actually the expense was incurred prior to the effective date of the change. So this would mean tracking the actions with respect to mandated benefits in all the jurisdictions and [1-144] making appropriate changes in our computation systems.

If I may carry that just step further, if you were making a change in a computer system then you sort of have to keep the old one in place for some period of time pending receipt of claims that were incurred prior to the effective date of the change. So my 54 systems, if you had 20 of them that changed, you add 20 more trails to be followed in the computer.

Q Now, let me stay with the computers for a minute. Couldn't computers solve some of these problems?

A Let me answer the question this way. The computer can be programmed to do almost anything that a person can do with pen and pencil. It's just a fast, accurate way to do something that otherwise can be done by a manual means. It's the only effective way to handle large volumes of data. I testified earlier that we received 1,294,000 Type A2 and B claims last year. So we would really have to do it by computer. But every time you make a change you have to reprogram. You have to debug that program to make sure it's working right, and the more of these trails or bubbles or whatever term you would [1-145] like to use are added on, it's going to increase the running time and the cost of processing claims.

Q Now, approximately what are your current administrative costs with respect to health plans?

A On a conservative basis I would say $5,000,000.

Q How do you get that figure? Is that just the A2 and B claims?

A Yes.

Q How do you get to that figure?

A Well, I have used a relatively conservative cost of $4 per claim, which multiplied by the almost 1.3 million claims is where I got to $5,000,000.

Q Now, do you have any opinion as to what the cost impact would be on these administrative items if mandated benefit laws expanded and increased?

MR. MONTGOMERY: Objection.

THE COURT: Sustained at this stage unless a better foundation is laid.

Q Is it one of your duties to follow mandated benefit laws?

A Yes, it is.

Q And have you noticed any trend with respect to such laws?

A There are more of them.

[1-146] Q And as part of your duties are you generally familiar with the doctrine specified in Wadsworth against Whalen?

A You mean what the—I'm sorry, I don't quite understand the term "doctrine."

THE COURT: Do you know what the case held?

Q Do you know what the holding was in Wadsworth against Whalen?

A Yes.

Q Now, if Wadsworth and Whalen becomes the rule and if the mandated benefit laws expand as they have been expanding as you testified, do you have any opinion as to how that would affect your administrative costs?

A It would increase it substantially.

Q By what factor?

A Easily five times.

Q What's the basis of that?

A Because of the additional trails that we would have to add to our system, our claim form changes, our processing. That's the basis of my opinion.

Q So you are talking administrative costs of an excess of $25,000,000 for General Electric alone?

A That is correct.

Q What would be the additional premium costs if mandated benefit laws continue to expand and if the [1-147] Wadsworth rule is upheld?

A Well, it would be the sum of the additional benefits themselves on an incurred basis that had been mandated, plus the additional administrative costs charged to us by the carrier, and, I assume, a piece on retention.

Q Could you quantify it with respect to the request for social worker service made by the union in 1979 and rejected at the collective bargaining tables?

A Yes.

Q Would you do so, please?

A As a part of my responsibility in costing alternatives that might be considered for inclusion in the package in negotiations, I did work with Metropolitan in arriving at some estimated costs of including social workers. The amounts that we calculated, depending upon the configuration of the benefit structure, were between

$1,600,000 and $2,700,000. But I would like to add, to make sure this is clear, that this was talking on a uniform basis, in other words, the same social worker benefit all over, not having variations by state jurisdictions.

Q And if there were variations, that would increase the cost?

A It would have to increase the cost.

[1-148] Q By several factors?

A It could be, yes, sir.

Q Now, has General Electric considered alternative means for coping with mandated benefit laws?

A We are.

Q And what are the means that you are considering?

A Non-insurance.

Q What would be your reasons for going non-insurance?

A Well, I understand that if we were not insured, that the mandated benefit laws would not apply, and we could have our uniform system of benefits.

Q Would you have any other reason for going non-insurance?

A No.

* * * *

[2-4]

JOHN D. MORRIS, Resumed

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Morris, you testified yesterday that there were three general classes of employees covered by the G.E. plan?

A I did.

Q Would you please repeat for me, please, those three classifications?

A They are wage or pay classes. There are exempt employees, non-exempt salaried employees, and hourly rated employees.

Q Now, are the benefits which each of those classes of employees receives under the plan all collectively bargained?

A Not all employees of the company are in collective [2-5] bargaining units.

Q Now, what percentage of the company's employees are in collective bargaining?

A About 40 percent.

Q Now, you also testified yesterday that since its inception the G.E. plan has been a uniform plan for all employees covered by the plan.

A I made that statement with respect to medical benefits.

Q Now, in reviewing the document that was submitted as Exhibit 1, you would agree however that the plan does take account of a number of different state laws in its benefit provision?

A The weekly sickness and accident benefits are subject to state disability benefits laws.

Q And those state disability benefit laws vary from state to state, correct?

A There are a limited number of laws; the provisions are not the same.

Q Now, referring specifically to page 23 of the document marked as Exhibit 1, that provides—excuse me, page 21—that's a special page applicable to New Jersey employees; isn't that true?

A That's correct.

[2-6] Q And doesn't that particular page reflect an additional cost per month that's deducted from the pay check of each New Jersey employee?

A That is correct. They contribute $.64 a month.

Q And is it also true that that New Jersey disability law results in the availability of benefits to New Jersey employees that are not otherwise available to G.E. employees?

A There are some minor benefits, yes.

Q Now, referring to page 23, that is a special provision applicable to New York employees, isn't that?

A Yes, it is.

Q And does the New York statute referred to in this page 23 also provide additional benefits not otherwise available to G.E. employees?

A There is an additional benefit which is that in the event of termination of employment, as stated on the page, coverage is continued for twenty-eight days unless the individual gains employment with another employer covered by the New York disability benefits law.

Q That's in effect a conversion provision?

A No, it's a continuation provision.

[2-7] Q A continuation provision?

A Yes.

Q Now, page 24, there's a special provision relative to Rhode Island employees?

A Yes, there is. Rhode Island has a monopolistic fund, so they pay the benefits and we, in effect, top the benefits off because our plan benefits are richer.

Q So, would it be fair to say that while the plan may be uniform, the benefits that are available to G.E. employees may vary to some extent, depending on the state—

MR. GREENFIELD: You're talking about disability benefits.

MR. MONTGOMERY: With respect to those three pages, I'm talking about.

THE COURT: Well, when you object, object.

MR. GREENFIELD: Object.

THE COURT: And don't object in the middle of the question, please.

MR. GREENFIELD: I object.

THE COURT: I don't think he's finished his question, are you, sir?

[2-8] MR. MONTGOMERY: No, your Honor.

THE COURT: That's what I figured. Why don't you ask your question, and then we'll allow time for an objection.

MR. MONTGOMERY: Thank you.

Q Would it be fair to say, Mr. Morris that while the G.E. plan may be uniform, the benefits which are available to G.E. employees in certain respects exhibited by example on pages 21 through 24 of Exhibit 1 may vary from state to state?

THE COURT: Now, is there an objection?

MR. GREENFIELD: Yes, your Honor, he's not specifying what type of benefit he's talking about.

THE COURT: Your objection's overruled; your rights are saved. You may answer, sir, if you understand the question.

A The plan document, which we are both looking at or have looked at, states that with respect to disability benefits, which is weekly sickness and accident, in other words, pay for an individual who is absent from work because of disability, do vary in very minor ways in four jurisdictions.

Q Now, do you consider these disability statutes in [2-9] these four states to be mandated benefit statutes, which is a term I think that you used in your direct examination yesterday?

MR. GREENFIELD: Your Honor, I would like to object on another ground. It's my understanding and I think I'm right, that disability statutes are not covered by ERISA at all.

THE COURT: That may be true, but the question, I believe, is proper. You can clear that up.

A Yes, I guess I would say the state has mandated that if you're going to do business in the state, you must have these particular benefits.

Q Now, do these various disability statutes, do they result in an additional administrative burden, cost burden, on your employee plans?

A As a practical matter, no.

Q If, hypothetically, all fifty states had different disability laws, would that add an administrative burden, as a practical matter, for your plan?

A I really can't answer that question because I don't know what the other statutes would say.

Q Now, you also testified yesterday, with respect to another document, Exhibit 3, which I believe is [2-10] a list of union demands in the most recent contract negotiations between the union and General Electric.

A That is correct.

Q And I believe you testified that in the course of negotiations with which you were personally familiar there was some give and take between the parties with respect to these various demands. Is that a fair summary of what your testimony was yesterday?

A Yes.

Q Now, would you also agree, however, that the participants in that collective bargaining process also recognized an obligation to comply with various differing state laws?

A I don't quite understand what—

Q Well, let me try to rephrase it. Did the parties to that negotiation understand that they had an obligation —strike that. Did the parties in that negotiation understand there were different state laws which were applicable to various portions of the benefit package?

MR. GREENFIELD: Objection. He cannot know what the parties understood, only what they [2-11] said.

THE COURT: Well, you asked the same question yourself.

MR. GREENFIELD: I do not think I asked him what other people, the operation of another person's mind.

THE COURT: You did.

MR. GREENFIELD: I shouldn't have.

THE COURT: I make mistakes every day. You can answer.

A The parties certainly were aware of the existence of the New York, California, Rhode Island and New Jersey disability benefits laws. They'd been in place, I think in California in the '40's.

Q Didn't the parties include expressly in the collective bargaining agreement a provision which preserved the right to vary the plan in accordance with any applicable state or federal law which may vary or require variance of the terms of the plan?

A That is correct.

Q Okay. And isn't that a traditional provision in collective bargaining agreements, that a savings provision for alterations in state or federal law?

A I can't answer that. I only know what—

[2-12] Q You've never seen such a provision in any other collective bargaining agreement in your experience with G.E.?

A Only in our agreements.

Q Okay. But that has been a provision that's been in your agreements down through the years?

A Yes, to the best of my knowledge.

* * * *

[2-16] Q Now, if you could, Mr. Morris, I'd like you to just briefly explain what the G.E. plan benefits are for treatment of mental or nervous conditions?

A I would put them in two categories. The first would be those benefits associated with confinements, hospital confinements. In that case, the hospital charges are paid in full and this, of course, all of this is subject to the lifetime maximum of $350,000. With respect to the services, of a psychiatrist or a psychologist, as defined in the plan, for a person who is confined in a hospital it would be a Type B expense reimbursable at the rate of 85 percent after the deductible. If the person has outpatient psychiatric care for an illness or condition, then the benefit rate is [2-17] 50 percent after the deductible.

Q Okay. Now, does the plan distinguish between, in its reimbursement, between general hospitals, accredited general hospitals, and mental hospitals, licensed by the state?

A As long as it meets the definition of hospital.

Q Well, would a mental hospital licensed by the Department of Public Health in Massachusetts meet the definition of hospital under your plan?

A I don't know, but I suspect it would.

Q And how about a private as opposed to a public mental hospital licensed by the Department of Public Health; do you think that would comply with the definition of hospital under your plan?

A I would expect so.

Q Now, are psychiatrists and psychologists reimbursed on an equal basis under the plan?

A Yes.

Q So there is no requirement that a psychologist may not be reimbursed except in the event of a referral by the physician or supervision by a physician?

A We have defined psychologist in the plan. And if the psychologist meets the definition of the [2-18] plan, he would be treated the same, assuming, of course, that the person is in fact treating an illness or injury condition.

Q Now, so far as I can tell, at least with respect to everything you've mentioned so far, the G.E. plan is in compliance with the minimum standards of the Massachusetts statute. What I'm trying to do is discover in what respect it does not comply since, unlike many of the plans that are issued here, it seems to comply. You mentioned yesterday social workers, and there was some testimony on direct that social workers are not covered by the G.E. plan.

A For mental health, they are not covered.

Q Now, is it your understanding that the Massachusetts statute requires a reimbursement for treatment by social workers?

A Yes.

Q Are you familiar with the Massachusetts statute?

A I have read it.

Q You've read it. It does not specifically mention social workers, does it?

A My recollection is that it does, but I have not read it for a while.

[2-19] Q Do you recall any mention in the Massachusetts statute of community mental health centers?

A My recollection is that it did mention health centers, mental health centers.

Q And those are community mental health centers licensed by the Commonwealth of Massachusetts?

A I would assume so.

Q Now, is treatment provided in the mental health center licensed by the state covered under the G.E. plan?

A Those services that are covered by the plan would be reimbursed.

Q No. Would services provided in such a setting be covered by the plan?

A If they meet—in other words, if a social worker charge came in, it would not be covered. If a psychologist's charge came in or a psychiatrist as defined in the plan, the benefits would be provided.

* * * *

[2-26] Q Do you know what portion of your current $5 million dollar administrative burden is attributable to the payment of claims for mental or nervous condition?

A No.

MR. MONTGOMERY: No more questions.

[2-27]

REDIRECT EXAMINATION
BY MR. GREENFIELD:

Q Mr. Morris, do your collectively bargained employees receive different benefits than other employees?

A Not health benefits; they're the same.

Q Now, with respect to the health benefits, do you first negotiate with the union?

A Yes.

Q And then you reach a benefit level that's collectively bargained?

A Yes.

Q And then those benefits are then made available for all employees?

A That's correct.

Q Whether they're unionized or not unionized?

A That's correct.

Q And whether it's the president or the super?

A That's correct.

Q I'd like to focus on the New Hampshire statute that you were asked about on cross-examination. That requires that the employee both, as you understand it, both reside and be employed in New Hampshire?

A Yes.

[2-28] Q So if an employee resided in New Hampshire but was temporarily employed in Vermont, as you understand that statute, it wouldn't be covered?

A That's correct.

Q So you would have to keep track of that employee's place of employment at any given time?

A As well as residence.

Q As well as residence. And the problem would become complicated if the employee were an itinerant worker who sometimes worked in one state and sometimes worked in another?

A Yes, it would.

Q Now, you were asked about pages 21 through 24 of Exhibit 1.

A Yes.

Q Do those pages relate to disability benefits?

A They do.

Q And to disability benefits only, am I correct?

A That's correct.

Q Now, how many states have enacted disability benefit laws?

A Five.

Q And for how long have these laws been around?

A With the exception of Hawaii, which is three or four [2-29] years, maybe five years ago, most of them,

the rest of them were enacted either in the late '40's or early '50's.

Q Now, could you describe disability insurance?

A Yes. The disability benefits which in the plan we call weekly sickness and accident benefits provide that if an employee is disabled because of a non-occupational illness or injury, benefits are payable during the duration of the disability; specifically, the benefit rate is 60 percent of the employee's, what we call, a normal straight time annual earnings—it's straight time pay on a regular basis, with a maximum currently of $200 a week. Benefits begin on the eighth day of disability, unless the individual is hospitalized earlier, for which case they start the first day of hospitalization, and they extend for a maximum of twenty-six weeks.

Q Now, the disability level, you just said 60 percent?

A Yes.

Q Is that higher than the disability levels provided for in the statutes in the five or six states that have the statutes?

A With the exception of New Jersey, which has a [2-30] two-thirds formula, it is higher. However, New Jersey, as I recall—I can look and see—currently has a maximum of $117 as compared to our $200, and as a practical matter I can't think of any cases I've heard about in recent years where our 60 percent of pay with the $200 max was not higher than the New Jersey benefit.

Q So, as a practical matter, what you are giving in that regard is more than the state statutes require?

A That is correct.

Q Now, do these disability statutes have any significant cost impliactions to General Electric?

A No.

Q Can you explain why not?

A Well, what the additions that were mandated through these disability benefit laws are really rare cases where anything is payable above the benefit level of our

plan or in addition to the benefit level. California, for example, now has benefits for thirty-nine weeks, but there are relatively few cases where we ever go twenty-six weeks of the total. Similarly, I mentioned earlier, New York requires continuation of coverage for twenty-eight [2-31] days. But, again, while we do have employees in New York who do terminate, they have to become disabled within that twenty-eight day period and before going to work for another employer to receive this benefit. So the frequency of these items is low.

Q Who bears the additional cost?

A The employees.

Q And you simply take something out of their payroll checks—

A That's correct.

Q In California and New York?

A In California, New York and New Jersey.

Q Now, do you have any data comparing the amount of claims under disability as compared to claims for A-2 and B benefits?

A Yes.

Q And what does that data show?

A We have about 50,000 weekly sickness and accident claims a year, and that compares with, as I recall, I testified 1,294,000 type A-2 and B claims a year.

Q So it's significantly less than 5 percent?

A Yes.

[2-32] MR. GREENFIELD: No other questions.

RECROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Morris, do you consider state laws which existed previous to the amendments to Title 7 concerning pregnancy-related disability to be disability laws?

A I—

Q Maybe I'm confusing you. Are you aware that various states have had laws requiring the payment by employers of pregnancy-related disability?

A Yes.

Q Do you consider those disability laws?

A If they require the payment of disability benefits, yes.

Q Now, are you familiar with a Massachusetts regulation promulgated by the Massachusetts Commission on Discrimination which required such payment by all employers in the Commonwealth?

A Yes.

Q You're familiar with that?

A I'm aware that such a thing exists.

Q Do you know when that particular law went into effect?

A I do not.

[2-33] Q Now, does the G.E. plan, did the G.E. plan prior to last year provide for such disability payment?

A The plan provided for payments beginning January 1, 1979.

Q So that the plan did not comply with the Massachusetts statute?

MR. GREENFIELD: Objection. That's a question of law.

THE COURT: Well, it could be a question of fact. It's a question of mixed fact and law, I guess. I'm going to go on the fact side and have the question answered. You can answer, sir, if you can, if you know.

A Well, would you state the question again? I'm sorry.

Q Prior to January 1 of 1979 did the General Electric employee benefit plan provide benefits for pregnancy-related disability?

A Yes and no. No, in the sense of weekly benefits. Yes, in that as far as medical expense coverage is concerned, the benefits for maternity-related expenses are identical to those for any other illness.

Q Did it provide any wage continuation?

[2-34] A I stated already, no, it did not.

Q Now, did the G.E. plan provide any wage continuation for other disabilities covered under the law?

A Yes.

MR. MONTGOMERY: Your Honor, may I have just a moment.

Q With respect to benefits for pregnancy-related disabilities prior to January 1, 1979, were the benefits for the plan standard across the country?

A Except as mandated by the five states.

Q Which five states?

A The California, New York, New Jersey, Rhode Island.

Q But not include Massachusetts?

A That's correct.

Q Are you aware of any other states besides the ones you just mentioned plus Massachusetts that had such statutes requiring payment for pregnancy-related disabilities on the same basis as for any other disabilities covered under a plan?

A I think there were other statutes.

* * * *

[2-35]

[TESTIMONY OF MARTIN J. FRANK]

DIRECT EXAMINATION

BY MR. DOPPELT:

Q Mr. Frank, please state your name, home and office address.

A My name is Martin J. Frank. I live at 106 Haverford Road, Pittsburgh, Pennsylvania. My office is at 600 Grant Street, Suite 4675, Pittsburgh, Pennsylvania.

Q Please trace your background briefly, starting with college.

A I graduated from the University of Michigan in 1958 with a mathematics degree. I then went to Mutual Life Insurance Company of New York as an actuarial trainee. I spent six and a half years at Mutual of New

York where my last few years I was in their group insurance department doing group insurance actuarial work as well as supervising the group underwriting portion of the group department. In 1964, I moved to Detroit, Michigan and became the actuarial consultant to the United Automobile Workers. I was in Detroit from 1964 to 1969, and in 1969 I went to Towers, Perrin, Forster & Crosby, where I am today. I've been there for eleven years and [2-36] have been in T.P.F. & C.'s Philadelphia office and now in their Pittsburgh consulting office.

Q What degrees do you hold?

A I have a Bachelor Degree in Mathematics from the University of Michigan, and I am a member of the Society of Actuaries, the Academy of Actuaries and the Conference of Actuaries in Public Practice.

Q Could you briefly explain what your responsibilities were at the United Auto Workers?

A I was the, as I said, my title was Actuarial Consultant. I reported to Mr. Walter Ruether, responsible for assisting the United Automobile Workers in their strategic plans for collective bargaining on employee benefit matters. In addition to working in that area, I also helped the UAW formulate its social policies with respect to pensions and supplemental unemployment benefits and health care. And in 1966, I helped the UAW work on Medicare legislation.

Q While at the UAW, were you involved in any specific collective bargaining negotiations?

A Yes.

Q Could you give us an example of one such negotiation?

[2-37] A Well, between 1964 and 1969, I was involved in what I like to call pattern-setting negotiations. Those were the negotiations in the big three automobile companies: Ford, GM and Chrysler. And I was also involved in a number of other parts supplier corporations like Dana Corporation, Champion Sparkplugs, and I was also involved in aerospace negotiations and in a number

of agricultural implement negotiations, like International Harvester, Caterpillar, John Deere Company.

Q You mentioned the phrase pattern-setting negotiations; could you briefly explain what you mean by that?

A Well, the UAW has a tradition of picking one of the major automobile companies and trying to hammer out an agreement with the major company. After that agreement is negotiated, then the UAW turns to the other big automobile manufacturers and tries to negotiate the same contract. The UAW represents about a million and a half workers, at least it did when I was employed at the UAW, and it then takes that contract from GM, Ford and Chrysler and moves on to the automobile implement [2-38] companies and other companies as well, who the UAW represents who are not even in the automobile industry.

Q What are your responsibilities now at Towers, Perrin, Forster & Crosby?

A Well, I'm the manager of TPF & C's Pittsburgh consulting office. I'm an actuarial employee benefits consultant for a number of major clients, and I am practice leader for TPF & C's labor relations consulting service on a worldwide basis.

Q Are you an officer or partner of TPF & C?

A Yes, I'm Vice-President of the firm, and I'm a principal in the firm; we're a corporation, not a partnership.

Q Can you briefly explain what TPF & C does?

A We're a management-consulting firm, and we work with a number of clients. We represent approximately 3,000 clients on a worldwide basis. To give you an idea of the clients we work for, we represent sixty of the Fortune 100 companies and approximately two hundred and sixty of the Fortune 500 companies. And we work in areas like employee benefit consulting, actuarial services, salary administration, executive compensation, and then we're into human resource [2-39] management services, such as labor relations, management succession, career development and into general management services,

such as organization development, strategic planning and a number of other service areas.

Q Do you provide services to a number of large companies?

A Yes, we do.

Q A number of Fortune 500 companies?

A Yes. I mentioned two hundred and sixty of the Fortune 500.

Q Could you explain what practice leader for labor relations means?

A Well, I'm responsible for the quality control of all of our services for all of those clients who we work with labor relations. We have approximately six practice leaders in the company, and we have 1,500 employees.

Q And so you are the top man at your company with respect to labor relations?

A Yes, sir.

Q What are your responsibilities, with respect to advising clients concerning collective bargaining matters? [2-40] A I work with clients not only in the Pittsburgh office but as I mentioned with clients all over the United States, and I help them in formulating their collective bargaining strategy in collective bargaining matters on employee benefits.

Q Do you actually participate in the collective bargaining process?

A Yes, I do. For most clients I'm involved in the process, but for some clients I'm just as an advisor, and I'm either contacted by telephone or I'll be on-site, but I won't be in the actual collective bargaining.

Q And, do you advise clients with respect to matters concerning health benefits for employees?

A Yes, I do.

Q Can you explain what is meant by the term health benefit?

A Well, I would define health benefits under a collective bargaining agreement as those benefits covering hospital reimbursement, surgical reimbursement, medical

reimbursement—that is, doctor bills, either inside or outside the hospital, or in an office or at home—I would [2-41] also include dental benefits. I would include eye care, vision care, those kinds of benefits I would deem health benefits.

Q At one time or another then, you have engaged in collective bargaining negotiations for both union and management?

A Yes, I have. Five years with the union movement and now eleven years on the other side of the bargaining table.

* * * *

[2-44] Q Could you describe the role of health benefits in the collective bargaining process?

A Well, I would consider, in my opinion, I would consider that health benefits are really a very central part of the collective bargaining agreement, and I guess I form that opinion on the basis of my experience in collective bargaining. The parties spend a lot of time discussing the health benefits portion of a collective bargaining [2-45] agreement.

Q Will the union ever consider what the significance of the health benefit package is with respect to the ratification of it?

A Yes.

THE COURT: I'm very sorry, I didn't hear the last—

Q With respect to the ratification vote on the collective bargaining agreement?

A Oh, yes, definitely. When the union is negotiating a contract it's very, very important that the contract that they end up be in the minds and the perceptions of the people who they represent, be what they wanted. And before a union can get a final agreement it must get a ratification vote from the members. And so it's terribly important that when the union puts its package together that that package cover a number of areas which have a very high visibility to the members they represent.

Q And health benefits is such an area?

A Oh, yes, sir.

Q Based on your experience, could you estimate the cost of employee fringe benefits in terms of [2-46] payroll?

A I think I would estimate that the cost of employee benefits in the United States is probably between 30 and 40 percent of payroll on an all-company basis.

Q Based on your experience could you estimate the percentage of health benefits as a percentage of employer payroll nationwide?

A I would say it would be between 5 and 10 percent of payroll.

Q Now, Mr. Frank, with respect to the companies that you advise would you describe the actual manner in which health benefits are negotiated in the collective bargaining process?

A Just like wages or just like pensions the union will make proposals for amendments to the collective bargaining agreement as it relates to health benefits. There will be proposals with respect to hospital reimbursements, deductibles, co-insurances, dental benefits, vision care benefits. Each particular item of health care is discussed in collective bargaining.

Q Will the union and employer generally discuss the need for or desirability of a given benefit on the [2-47] table?

A Yes. It's very common for the parties to discuss philosophically, does this benefit make sense for the union's members and for the employees of the corporation. Is it too costly? What will the utilization be? How much will the administrative expense be? Will people understand the benefit? Are other benefits more important to the members? So, yes, it's discussed in great detail.

Q And on a practical level, will the employer and union generally discuss the detail aspects of the coverage such as co-insurance?

A Yes, limits, co-insurances, deductibles, first-day coverage, eighth-day coverage. It's discussed in great detail.

Q Now, how common is this type of bargaining over mental and nervous-type benefits?

A Very common.

Q Have you been involved in any recent collective bargaining negotiations in which mental and nervous benefits have been discussed?

A Yes, I have.

Q Could you give us an example of one such—

A I was involved in the B.F. Goodrich negotiations [2-48] with United Rubber Workers in Columbus, Ohio when the B.F. Goodrich Company made their pattern settlement. I use the term pattern just like I've used it in the automobile because that pattern settlement then evolved with the coverage for the rest of the rubber industry.

MR. DOPPELT: I'd like to ask the reporter to mark as Exhibit 9 for Identification, the document headed, Agreement on Employee Benefit Programs, dated September 6, 1976 between the B.F. Goodrich Company and International Union of United Rubber, Cork, Linoleum and Plastic Workers of America and local unions.

THE COURT: Show it first—

MR. DOPPELT: Opposing counsel has seen it.

MR. MONTGOMERY: And we don't object to its admission.

(Agreement, above-referred to, marked Exhibit No. 9)

MR. DOPPELT: May I approach the witness, your Honor?

THE COURT: Let me read this over, please.

[2-49] Q Mr. Frank, I hand you Exhibit 9 and ask you if you can explain what that document represents.

A Well, this is page 49 of the agreement on employee benefits and it highlights Section D which is the mental,

psychoneurotic or personality disorder conditions benefit that was negotiated in the 1976 agreement.

Q And what did that benefit provide with respect to the amount of coverage for the mental benefits?

A Well, subject to various deductibles it provides a $30 per professional services visit at the rate of 50 percent co-insurance, and there's a maximum of $750 per calendar year.

Q Did the union develop a proposal with respect to this benefit for the 1979 negotiations?

A Yes, they did.

MR. DOPPELT: I'd like the reporter now to mark as Exhibit 10 for admission into evidence, a document headed Columbus Ohio 2/26/79, Union Proposal.

THE COURT: On behalf of the Commonwealth?

MS. KELLY: No objection, your Honor.

THE COURT: It may be marked Exhibit 10.

(Proposal, above-referred to, marked Exhibit No. 10)

[2-50] Q Mr. Frank, is Exhibit 10 a copy of the union proposal with respect to the mental and nervous benefits?

A Yes, it is.

Q And could you tell us what the union proposal states with respect to the amount of coverage per visit and maximum per year?

A Well, the union was demanding that the $30 benefit be increased to $50 and that the maximum benefit be increased from $750 to $1,000.

Q Would this document have been provided to management with respect to 1979 collective bargaining negotiations?

A Yes, this was passed across the bargaining table.

Q And was this proposal discussed in the 1979 negotiations?

A I'm sure it was.

Q And was an agreement reached with respect to this provision?

A Yes, there was.

MR. DOPPELT: I'd like to ask the reporter to mark as Exhibit 11, with the Commonwealth's permission for admission, a document headed 12.3(a)(b).

[2-51] MS. KELLY: The Commonwealth has no objection, your Honor.

THE COURT: Okay, it may be marked.

(Document, above-referred to, marked Exhibit No. 11)

THE COURT: This apparently is some sort of—apparently some sort of amended—amended to be attached to the contract, or something like that?

MR. DOPPELT: I will ask the witness to explain.

THE COURT: I want to write it in my book first, so I can understand it.

MR. DOPPELT: As I understand it, it is a page from the 1979 agreement, which refers to the 1976 agreement.

THE COURT: Okay. So this is like one that is to be amended to the contract?

MR. DOPPELT: Right.

Q Mr. Frank, could you explain what Exhibit 11 is, please?

A This is a page from the memorandum of agreement where the parties reached agreement and summarized the changes that would be effectuated in the 1979 agreement. And specifically here, it shows that [2-52] the daily rate, or the per visit rate, excuse me, which was $30 would now go to $45 and that the $750 maximum would go to $1125.

THE COURT: We're going to take a short recess. Is that okay? We won't make this the usual long morning recess, just about five minutes.

(Recess.)

Q Mr. Frank, just so that the record is clear, would you please explain what precisely Exhibit 11 is once more?

A This is a page from what I like to refer to as the memorandum of understanding between the union and management just after collective bargaining agreement has been signed. And this is not the legal language that goes into the agreement; this is just a memorandum of understanding, and then it's written up after the ratification vote.

Q And this is the memorandum for the 1979 negotiations?

A Yes, it is.

Q And the provision that you were reading from with respect to the $45 and $1,125 increases is 12.7(d)?

A Yes.

Q And that provision refers back to the '76 agreement?

[2-53] A Yes.

Q What are some of the factors involved in the union and the employer reaching an agreement on the final package?

A Well, some of the factors involved are the cost, the total cost of the program, whether or not the union needs either more in wages or more in health insurance or more in pension. It's a collective bargaining process, and it's the whole package that comes into being not just parts of the package.

Q Will the parties reach final agreement on each aspect of the packages as they move through negotiations, or will agreement await the end of negotiations?

A It's most common for the total agreement to come into being in the last hours of negotiations.

Q And will the union and the employer have any sort of cost estimates in mind for the total package that they're willing to accept?

A It's common for them to discuss costs. There are a number of negotiations that I've been in where costs

were never discussed at the bargaining table, but rather philosophical arguments about whether or not a benefit should be in the program.

[2-54] Q Before the negotiations begin will the employer or the union formulate some general notion as to what type of overall package they are willing to accept?

A Yes. It's common for the chief negotiator for the company to have a maximum economic point at which he can no longer go over. He has direction from top management for the total cost of the package. On the other side of the table, the union leaders have a feeling as to the minimum amount that they can settle on either from a cost standpoint or from a benefit standpoint. This again, as I mentioned a few moments ago, you have to go back with that agreement and get a ratification vote, so it's terribly important to deliver an agreement to the company.

Q What, if any, is the relationship between the resolution of disputes or issues in the health benefit area and the resolution of issues in other areas such as wages or pensions?

A They're very similar. I've been in negotiations where health benefits were traded for wage increases or where wage increases or money that was set aside for wage increases earlier on in negotiations were [2-55] set aside for pension increases as the whole package comes into being for final agreement.

Q Will certain employers purchase group health insurance policies to implement the promises contained in the collective bargaining agreement with respect to health benefits?

A Yes.

Q And what will the relationship be between the benefits as set forth in the collective bargaining and the benefits to be provided through the insurance policy?

A Identical.

Q Are you aware that there are a number of state laws which require group insurance policies to provide

certain specified health benefits regardless of the actual terms of the collective bargaining agreement?

A It's my understanding that there are state laws like that, yes.

Q Are you aware that the Commonwealth of Massachusetts has enacted such a law?

A Yes, I am.

Q Have you read the Massachusetts statute?

A Yes, I have.

[2-56] Q Do you know whether other states have similar type laws?

A It's my understanding that there are similar type laws in other states.

Q Based on your experience, do you have an opinion as to what the effect of these laws will be on the collective bargaining process and the agreements reached in that process?

A Well, it's my opinion that state laws like this requiring parties to agree beforehand can be very disruptive to the collective bargaining process and could possibly cause problems for the whole process of collective bargaining. It seems to me that if parties are going to negotiate over employee benefit matters, then they should have freedom as to bargain over those benefit matters and for them to come to the bargaining table and for part of the contract to be already agreed to will make it difficult for the free collective bargaining process to continue. Also, it's terribly important in collective bargaining, in my opinion, for the parties to have maximum flexibility. And to the extent that there are coverages which are required, there is less [2-57] flexibility, and there's obviously less trading that can be done in collective bargaining because there's only so much money the parties can spend. And if part of the agreement is stipulated, there's less money available for other things that the union might want or that management might want in the collective bargaining process.

MR. DOPPELT: No further questions

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Mr. Frank, do you know whether with respect to the B.F. Goodrich agreement that all of the persons who are entitled to benefits under the plan are also subject to the collective bargaining agreement?

A The agreement that you have?

Q Yes.

A It's only for employers who are covered by the United Rubber Workers settlement at various locations around the United States. You're asking are there other employees who are not covered by this collective bargaining agreement who are covered by the same plan?

Q That's right.

A I'm not sure.

Q Are you familiar with the nature of the benefits [2-58] provided to non-union employees of B.F. Goodrich?

A No, I'm sorry, sir, I'm not. My only involvement was assisting B.F. Goodrich in bargaining with this particular union.

Q Well, you do know that this plan does not apply to any other employees?

A No, I don't.

Q So it may—

A Yes, it may.

Q There're benefits included in that plan which may very well apply to non-union employees?

A Yes, it might.

Q Would it be uncommon in your experience for such a plan which has been collectively bargained to apply to non-union employees also?

A I can't say whether it's common or not. It depends on the industry. It depends on the power of the particular union. It depends on whether the company is multi-divisional or multi-product. It's very difficult for me to answer whether it's common or not.

Q Okay. Now, you testified that in your experience, to some extent that benefits, that health insurance benefits are specifically discussed in [2-59] detail in the collective bargaining process. Do you have any experience with collective bargaining negotiations in which the discussion really centers on the level of contribution by the employer to an employee plan as opposed to specific benefits?

A I'm knowledgeable that that occurs, but I do very, very little work in that area.

Q But that does occur?

A It does occur.

Q Now, the collective bargaining agreements that you have experience with, does the negotiation process take account of the variability in state laws across the country to which a plan might be applicable?

A You're referring to a particular kind of a plan now or any kind of plan?

Q I'm asking you a general question. You testified generally with respect to the bargaining process, and I want to know whether the bargaining process takes account of and how it takes account of the various state laws that might apply to the types of benefits which are being provided?

A It might well do that, yes.

[2-60] Q Might there be specific discussion in the course of the bargaining process of the various state laws which might apply to a particular benefit?

A Yes.

Q And is it common in your experience for the plan which results from the negotiations to vary to meet the terms of various state statutes or regulations?

A With respect to the clients who I represent, that would be very unusual because of the level of benefits that are provided for employees on a company-wide basis.

Q So, in general, your benefits exceed the minimum state requirements and, therefore, there would not be an issue with respect to the applicability of those state laws?

A In most cases I would say yes.

Q Now, I'm referring to a document which I don't believe is going to be marked, but it is the B. F. Goodrich agreement, and it mentions on page 1 the term supplemental, local supplemental agreements. Are you familiar with that term?

A Yes, I am.

Q And is it true that the B. F. Goodrich agreement is [2-61] subject to and does not override local supplemental agreements?

A Yes, but the term as used in the B. F. Goodrich agreement refers to local general collective bargaining agreements. That is to say, with respect to working conditions and seniority clauses and union security clauses not with respect to employee benefits. That agreement that you have in your hand is the agreement for all United Rubber Worker employees who work for B. F. Goodrich no matter where the work or what division they're in.

Q What are the types of subjects which are considered in local supplemental agreements?

A It's very difficult for me to answer that question without having those supplemental agreements in front of me, but typically, they're working conditions, subcontracting, time off for lunch, the rate at which the assembly line moves. It's what I refer to as general collective bargaining issues and not economic matters, not like wages and supplemental unemployment benefits or pensions.

Q Well, you just mentioned time off for meals and things like that. Are you aware that various states have different requirements applicable to provisions [2-62] by employers for mealtime?

A No, I wasn't.

Q Mr. Frank, are you familiar with the provision in this agreement which provides that the company may provide benefits through a health maintenance organization subject to applicable state or federal law?

A I wasn't familiar with it, but that doesn't surprise me that a provision like that would be in there.

Q Is that a common provision?

A Yes.

Q Now, you testified that you're familar with various state statutes which mandate certain level of benefits for the treatment of mental and nervous conditions. Are you aware of—

A I said I know of them; I'm not necessarily familiar with them.

Q Do you know of other examples of statutes or regulations which regulate other aspects of the employee-employer relationship which differ from state to state?

A Yes, the disability provision that was mentioned earlier this morning.

Q Have you participated in any collective bargaining [2-63] negotiations which have considered, for instance, the subject of pregnancy-related disabilities that were discussed this morning?

A Yes, I have been in negotiations.

Q Could you describe the nature of those discussions?

A The nature of the discussions would be whether or not a pregnancy-related disability would be treated as if it was any other disability. In other words, whether the benefits would be paid on the same basis as if it were any other kind of non-occupational or occupational disability.

Q In your experience, was any consideration given in any of those discussions to the existence of laws in any of the states which mandated such benefits by employers?

A Yes, I can think of one negotiation I was in where it was discussed.

Q And what was the result of that discussion of that state law?

A That particular discussion was a company in Toledo, Ohio, and they had employees in the State of Michigan, and there was a question whether or not the employees had to be covered, those disabilities that were pregnancy-related. And, as a matter of [2-64] fact, the parties could not reach agreement on that subject because

of the vagueness of whether or not those parties would be covered the same as any other illness. It actually was very disruptive to collective bargaining.

Q Have there been any other occasions that you can recall on which that subject has been discussed?

A Not offhand, sir.

Q But you do believe it was disruptive?

A In this particular case that I was involved in, yes, it was.

Q Now, are you aware of the fact that the various states have different laws mandating different holidays that have to be provided by employers to employees, state holidays?

A Yes, I am aware of that, yes. We have an office here in Boston.

Q And have you participated in any collective bargaining negotiations at which the subject of the differences among the holiday entitlement among the various states has been discussed?

A No, sir, I'm only involved in employee benefits, and the subject of holidays would not be discussed as an employee benefit in a collective bargaining [2-65] agreement, at least the particular—

Q So that is not a fringe benefit?

A No, at least that particular area which I am involved in.

Q Now, are you aware that to some degree the minimum wage may vary from state to state?

A Yes.

Q Have you ever participated in a collective bargaining negotiation at which the difference in the minimum wage from one state to another has been discussed?

A Never discussed in any negotiations that I've been in because of the level of the wages.

Q Are you aware that various states have various laws which address the subject of age discrimination?

A Yes, I am aware of that.

Q Have you participated in any collective bargaining negotiations in which they discussed the differences in those state provisions?

A Yes, I have.

Q And what have been the nature of those discussions?

A In one negotiation in California, which has a provision which is more liberal than the recent age discrimination employment act of 1978 amendment, [2-66] and, of course, the pension plan had to take that into account.

Q So, in fact, it did take it into account. Was that disruptive to the collective bargaining process?

A It certainly was because the bargaining unit was not just California employees but employees on a company-wide basis, and so the pension plan when it was negotiated with the bargaining committee that represented employees from the entire company from plants all over the country, we had to discuss how employees would be allowed to stay on after age 65 in some states versus other states, and we had to arrive at an agreement that made sense to the whole company, and there were obviously employees who were not Californians who had very little interest in discussing that subject.

Q And, as a result of that bargaining agreement were the benefits, the rights of California employees under that agreement different than with respect to age and retirement than employees in the rest of the country?

A In this particular agreement it ended up that the benefits for employees outside of California were [2-67] the same as California employees, and that is why it was disruptive. Because as part of the whole collective bargaining process, money had to be diverted from other portions of the agreement to pick up the additional cost of providing non-California employees the same benefits as California employees.

Q Well, would you then conclude, in general, that any state statute or regulation which has the practical effect of requiring an additional benefit for employees in

one state may be disruptive to the collective bargaining process?

A Would you repeat the very first part of the question?

Q Maybe that wasn't clear. Would you conclude that any state statute which requires a benefit to be provided to employees in that state which is different than what the parties contemplate for the rest of the country may be disruptive to the collective bargaining process?

A It may be disruptive, yes.

* * * *

[2-68]

[TESTIMONY OF WILLIAM L. HYLAND]

DIRECT EXAMINATION
BY MR. McGOVERN:

Q Please state your name and address, sir.

A My name is William L. Hyland. I live at 186 Bueno Vista Drive, Ringwood, New Jersey.

Q And by whom are you employed?

A GTE Service Corporation.

Q What is your business address, Mr. Hyland?

A 1 Stamford Forum, Stamford, Connecticut.

Q What relationship does GTE Service Corporation bear to GTE Corporation itself?

A GTE Service Corporation is a wholly owned subsidiary of General Telephone and Electronics Corporation, General Telephone and Electronics Corporation being [2-69] a holding company and having no employees. GTE Service Corporation has employees that render services to the parent and its subsidiaries on a common basis.

Q The official name of the parent then is—

A General Telephone and Electronics Corporation.

Q And the official name of the service company is—

A GTE Service Corporation.

Q What businesses are General Telephone and Electronics and its various subsidiaries engaged in?

A We're in the telecommunications business. We operate telephone operating companies in thirty states in the United States and three or four foreign jurisdictions and we manufacture telecommunications equipment and electronic products including consumer electronics and related products, allied products.

Q Consumer electronics get you into TVs, radios?

A Televisions, radios, stereo.

Q That is your Sylvania line?

A Yes, those products are branded Sylvania.

Q What is your position, Mr. Hyland, with GTE Service Corporation?

A I'm Vice President, Insurance.

[2-70] Q And can you give the Court, if you will, a brief description of your duties and responsibilities as Vice President, Insurance?

A I supervise the insurance and pensions department of GTE Service Corporation. The insurance and pensions department consists of four sections: the Corporate Insurance Section, which is concerned with the insurance matters of the corporation itself, the insurance the corporation may purchase to protect its own assets; Loss Prevention and Safety, employee benefits as group insurance, or what we call employee insurance; and pensions, savings and investments and thrift plans.

* * * *

[2-75] Q I'll ask you more about your participation in collective bargaining later. But now, moving on, Mr. Hyland, can you give the Court, if you will, an overview or summary of the various benefits that GTE provides for its employees?

A Yes. We provide a comprehensive package of employee benefits on a non-contributry basis; that is, the employees do not make any contributions toward the cost of the benefits, and they range from income continuance, survivors' benefits for life insurance, medical benefits, which include health, hospitalization, surgical, dental benefits, retirement benefits, including pension

plans, [2-76] savings and retirement plans; employee stock ownership plans and employee stock option plans.

Q Now, in particular, is there a GTE health benefits plan?

A Yes, there is.

Q Can you tell us something about that, for example, the extent to which it's a uniform plan, who it covers and so on?

A The GTE medical benefits plan applies to all of the employees employed in the United States on a uniform basis, which they're about—at least on December 31, were about 179,000—I'm sorry, about 167,000 employees.

Q It covers union as well as non-union employees?

A It covers union and non-union employees, yes.

Q Does it cover, to use Mr. Greenfield's language, does it cover the high positions, the president, down to the low positions, the sweeper?

A Yes, it covers all employees irrespective of their position.

Q And it covers, you say, approximately 167,000 of the state employees. Have you got the figure for the Massachusetts employees?

A Yes, sir. It's 7,100 employees in Massachusetts.

[2-77] Q 7,145, is that it?

A You want the exact number?

Q Yes.

A 7,145.

Q In how many Massachusetts locations?

A We have thirty locations in Massachusetts.

Q And does this GTE health benefits plan cover the dependents?

A Yes, it does.

Q What's the arrangement with respect to dependents?

A Any dependent, as we define it in the plan, is covered under the plan for the same benefits that the employees are covered. A dependent, as we define it is the employee's spouse and any dependent children who live

with the employee in a child-parent relationship, including students attending accredited colleges up to age 25.

Q Is there a contribution the employee must make?

A No. Our plans are not contributory.

Q Non-contributory?

A Yes.

Q And about how many of these dependents are covered in the United States?

A I have to kind of extrapolate. Most companies do [2-78] have approximately two and a half dependents per employee. So if we're talking about 167,000 employees,—excuse me just a moment—we're talking about approximately 584,000 employees and dependents. That would be 167,000 employees and 417,000 dependents. To that we have to add 16,000 retirees who are also covered under the plan and approximately 8,000 other employees who are on long-term disability or approved leave of absence. We have a total of approximately 608,000 plan participants in the United States.

Q Is this an insured plan?

A Yes, it is.

Q And with what company is this plan insured?

A The plan is insured with the Travelers Insurance Company.

* * * *

[2-80] Q Would you simply give the Court a short description of the various health benefits which the GTE health benefits plan currently makes available?

A Yes. In the health benefits program we include: hospitalization, surgical procedures, miscellaneous hospital charges in connection with surgical procedures, such as the rent or fee for operating rooms, supplemental accident benefits for emergency treatment in the event of an accident, mental health coverage, as well as dental benefits.

Q Now, Mr. Hyland, has GTE always followed this policy of making available to its employees a uniform health benefits plan, where all the employees receive essentially the same benefits?

A No, it hasn't. GTE as its presently constituted originated as a small telephone company that grew through acquisition and mergers of other telephone companies and other electronic manufacturing companies to the form in which it's constituted today. In this acquisition and merger process, [2-81] which took place largely in the latter 1940's and 1950's, we acquired not only several subsidiaries, but with them the various employee benefit plans of those subsidiaries. The plans were divergent in nature from one to the other, as well as being funded under different schemes, different insurance carriers. In the beginning, the very late 1950's early 1960's, there was considerable employee dissatisfaction with this arrangement, where the employees knew that other sister companies of GTE employees enjoyed a greater benefit than they might enjoy in a particular area. We had considerable difficulty in transferring management employees from one subsidiary to the other and, in fact, it had several occasions at that time where employees would refuse to accept a transfer. Because of the benefits that he received he would lose by accepting the transfer. The process of managing the employee benefit plan was considerably cumbersome. Each one of the subsidiaries had at least one, and sometimes two or three insurance coordinators, who spent their time administering the plans on a local subsidiary basis. This, of course, involved considerable cost to maintain a [2-82] staff of employees to keep track of the various benefits and to administer them in this manner.

Beginning in 1962, it was determined that GTE would be better served having a single plan for all of its employees, beginning with all of its management employees and then ending with all of its union employees, all the employees who were represented by a bargaining unit, as those plans came up for bargaining and the benefit levels were bargained for.

Q You had a process then of consolidating all of these twenty separate health benefit plans, which ultimately ended into the one—

A Into the GTE plan, that's correct.

Q —the GTE uniform plan?

A Yes. We had somewhere in the neighborhood of about twenty different plans.

Q And how long a period did this process take?

A Well, the entire process took approximately ten years, nine years. The management employees benefits were instituted immediately, and that included management employees as well as non-management employees who were not members of a collective bargaining unit. The employees who were members of [2-83] a collective bargaining unit took a considerable longer period of time in that we obviously needed to bargain their benefits for them and, in general, we have three-year union contracts. So that it took three shots, if you will, or three steps to bring the level of benefits for the various unions into a single plan. So, three contracts, three years, is approximately nine years.

Q What consequences did this process of consolidating the plans into a uniform plan have with respect to the size of your administrative staff?

A Today, I operate within my department, which is a total twenty-five people, six of those people are dedicated to the employee insurance section. Prior to our consolidation there were in the neighborhood of forty employees employed in various locations at GTE doing the same work. So, in a sense, we reduced the administrative staff to administer the employee benefit plans from about forty now to six.

Q At a consequent reduction in costs?

A Obviously, yes.

Q What consequences did this program have with respect to the employee relations in your company?

[2-84] A The complaints that we had been receiving with respect to the variance of benefits have literally disappeared. We don't receive that complaint anymore.

Q What is your percentage ratio for what you might call controversies or errors as a percentage of total claims?

A For the plan year ending 1979, the error factor—what we term the error factor—was less than 1 percent.

Q Do you have a uniform claims handling procedure nationwide, Mr. Hyland?

A Yes. There's only one procedure that's employed; there's only one form. The same form is used throughout the country for each employee. They simply complete that single form, submits it to the Travelers together with his incurred medical expenses and is paid directly from the Travelers, and there are no exceptions to that.

Q Do you have one set of instructions, claims handling instructions that are used in connection with this procedure?

A We do not. GTE only has one set of instructions and that is to give the employee the form and tell [2-85] him to mail it to the Travelers. The Travelers, however, has a set of instructions called the Claims Manual that they prepare in their home office in Hartford and is distributed to their various claims officers throughout the country that handle GTE claims. But there's only one manual.

Q When you have a uniform set-up like this, a uniform procedure, what consequence does this have with respect to the level of professional training that is needed for your claims handling personnel?

A The majority of claims, and we're estimating 98 to 99 percent of the claims that are processed, you employ a claims clerk that would require a minimal education, probably a high school education, with minimal training in the insurance business because they're processing on a routine basis the same type of claim that they see day in and day out. So that the claims processing is done at a

relatively low level, low insofar as educational requirements are concerned. We get higher level employees, higher trained employees involved in a few of the claims where errors have been committed, and on very few claims that are controverted we might have [2-86] to elevate to the level of an attorney.

Q All right, sir. Now, an incidental question with respect to the claims handling procedure in Massachusetts. GTE has a Fall River plan, does it not?

A Yes, that's right.

Q And where is it that all of the claims, the health benefit claims of the Fall River employees are processed, decided upon and paid?

A Providence, Rhode Island.

Q And with respect, on the contrary, with respect to the Salem plant of GTE where is it that the claims of those employees are processed, decided upon and paid?

A Danvers, Massachusetts.

Q Now, Mr. Hyland, to what extent has collective bargaining been involved in the formation of GTE's health benefits plan?

A I'm sorry, you said to what extent or to what respect?

A To what extent.

A The collective bargaining process has been involved to the extent of providing benefits to our employees because our employee benefits program, as it applies [2-87] to the members of the bargaining unit, is a bargaining plan. That is, it's negotiated between management and union, or the collective bargaining agent, so the union's input into that plan is taken into account, and the plan that we have is by agreement with the union members.

Q How many of GTE's operating subsidiaries have engaged in collective bargaining?

A All of them.

Q What unions are we talking about in this connection?

A We deal nationally, negotiate nationally with the International Union of Electrical, Radio and Machine

Workers, IUE, AFL-CIO. That covers substantially all of the products group or the manufacturing portion of our company. The telephone communications portion, the telephone operating companies, deal primarily with the Communication Workers of America, and in two cases, the International Brotherhood of Electrical Workers, who do not participate in the coalition bargaining of the IEU.

Q So, the IUE bargaining is coalition bargaining?

A Yes, sir.

Q What has been the typical period of years for the term of a GTE collective bargaining agreement?

[2-88] A Three years.

Q Now, as corporate insurance manager, director of insurance and now Vice-President of Insurance, have your duties and responsibilities involved you in any way with collective bargaining and health benefits?

A Yes, it has.

Q Would you describe how they have involved you?

A Yes. At the beginning, in benefit design and benefit planning we worked together with the human resources department in developing a plan that GTE is willing to bargain. When the union contract is being bargained—we're now in the bargaining process—I and my staff hold ourselves available to the persons who are negotiating at the table on a daily basis by telephone as the union and the negotiating committee negotiates any changes in the package that we might be offering or demands, a list of demands that the union has made. We, in turn, are in constant contact with the Travelers where costing of any changes of proposed benefits or demanded benefits are necessary. In situations where benefits might have become a strike issue or are a strike issue either myself or members of my staff will [2-89] actually check into the hotel where the bargaining is being conducted so that we're immediately available to the people doing the negotiation.

Q Has it been GTE's practice to bargain with respect to specific health benefits or have they, on the other hand, bargained on merely the level of monetary contributions?

A We only bargain with respect to the level of benefits; we never bargain and refuse to bargain with respect to contribution levels.

Q And that's true, in particular, or specifically of health benefits; is that correct?

A That's correct.

Q And this is true, even more specifically, with respect to mental health care?

A That is also correct.

* * * *

[2-91] Q Now, Mr. Hyland, making reference where you wish to do so to these three collective bargaining agreements, Exhibits 12, 13 and 14, would you summarize for us GTE's collective bargaining history over the last seven or eight years with respect to mental health care benefits?

A Yes. The agreement dated September 3, 1973 through November 15, 1976, there appears an amendment to the employee benefit plans that provides for [2-92] out-patient mental health services. Until this time in-patient mental health services had always been provided as part of the hospitalization program, and for the first time in 1973 we provided an out-patient benefit. Shall I read it?

Q No, I don't think it's necessary to read it. And then what happened in 1976?

A In 1976 that benefit was then improved by raising the per visit amount that was to be payable under the plan and reducing the amount of visits in any twelve consecutive months that would be permitted under the plan and defined whose services would be reimbursed under the plan; the person who was providing the services was defined.

Q Would you characterize that as an improved out-patient benefit?

A Yes, it is.

Q Incidentally, do these agreements have more scope and more applicability than the single plan that happens to be on the cover there?

A Yes.

Q The single location.

A The single location. The bargaining contract is the interior of the booklet, if you will, and that [2-93] is the same for all employees who are covered under the IUE contract. At each location we print a different cover with that location's address on it, so that each employee at that location has his own copy of the union contract. The main reason for that is that there are some variations with respect to holidays, lunchroom facilities and parking facilities and things that apply only to a particular location that don't apply to a national organization.

Q And now would you continue what happened as a result of the bargaining in 1979?

A In 1979 the benefits that had been bargained for in 1976 were extended to include dependents with respect to out-patient mental and nervous conditions.

MR. MC GOVERN: Your Honor, I'm going to place a copy of Section 47B in front of the witness, and I have also one for the Court.

Q Mr. Hyland, you're familiar, are you not, with the term mandated benefit laws?

A Yes, I am.

Q What's your understanding of that term?

A The state mandated benefit laws are where a particular state sets as a minimum standard benefits that are [2-94] to be provided under insurance contracts issued either in or outside of that state.

Q And in the course of your duties as GTE's Director of Insurance and Vice-President of Insurance are you generally familiar with the Massachusetts mandated benefits law and mental health benefits?

A In general, yes.

Q Now, do you have a copy of Section 47B there in front of you?

A I do.

Q Directing your attention to subparagraph a, about in the middle of the page, do you see where it says: "In the case of benefits based upon confinement as an in-patient in a mental hospital under the direction and supervision of the Department of Mental Health"—does the GTE health benefits plan provide benefits for confinement as an in-patient in a mental hospital under the direction and supervision of the Department of Mental Health?

A It provides mental and nervous condition benefits while confined as an in-patient in a hospital, as is defined in the summary plan description.

Q Well, would this kind of mental hospital comply [2-95] with the definition that you have in your plan? Would it always comply?

A I can't answer that it always will. In general, from reading the words I would say that probably in most cases it would. But always, I don't know.

Q If you had a licensed mental hospital that was not, however, accredited as a general hospital, would it apply?

A It might not. It may, but it might not. It may not meet other criteria or stipulations as defined in the plan.

Q Where are the criteria that you're addressing; is that on page 31? You can make reference, if you will, to the latest summary plan description, Exhibit 17.

A The latest summary plan description on page 30 defines a hospital. Shall I read that? That's 17.

Q And it's pages 30 and 31. Looking over the, I believe it is the three or four paragraphs here that define what types of hospital GTE is talking about under this plan, might you well have a licensed mental hospital under this statutory paragraph a that would not come within some of [2-96] those paragraphs?

A Yes, it's conceivable that it would not.

Q The accreditation, for example, that is being talked about at the top of page 1 is an accreditation as a general hospital, is it not?

A Yes.

Q So you might well have a licensed mental hospital that is not accredited as a general hospital?

A That's correct.

Q Do you know whether a licensed mental hospital in all cases meet the Medicare type of hospital standard that is in the second paragraph there?

A No, I do not know.

Q Are these some of the decisions that would have to be made by claims personnel, assuming the Mass. statute were applicable and others like it?

A Exactly.

Q How about the third category of hospital? Would a licensed mental hospital necessarily pass those tests?

A Not necessarily, no.

Q How would you have difficulty knowing whether it did or didn't?

A You would have to examine the services that are [2-97] being provided by that mental hospital, and if it met the conditions of the third test, coverage would then be provided. If it failed to meet those conditions, then coverage would not be provided. But, someone would have to make that determination and make that judgment.

Q Directing your attention, Mr. Hyland, back to the paragraph (b) under the statute, do you see where that seems to refer to confinement as an in-patient in a licensed or accredited general hospital; do you see those words?

A Yes.

Q Now, does the GTE health benefits plan generally cover that sort of thing?

A Yes. Confinement in a licensed general hospital for mental and nervous disorders is treated the same as any other illness.

Q Dropping down to paragraph c, skipping over the first line which has to do with the monetary level, I want to focus on that first clause that appears to relate to services by an entity called, and I quote, "Comprehensive

health service organization." Does the GTE health benefits plan provide benefits for care in an organization so described?

[2-98] A I don't know. We don't use those terms in the plan, nor in the summary plan description, and I don't know what the terms "comprehensive health service organization" really mean; they're not defined.

Q Referring again to the latest summary plan descriptions, can you tell the Court what page the basic mental health care provisions appear on?

A They appear on page 12.

THE COURT: We're still on Exhibit 17?

MR. MC GOVERN: Yes, we are, your Honor.

Q Now, I direct your attention to the paragraph under the heading, Mental Health Services, on page 12 of Exhibit 17. That does indicate that you will provide benefit coverage for a community mental health center under certain circumstances; am I correct?

A That's correct.

Q But do you see anywhere there any coverage for something called comprehensive health services organization?

A No, I do not.

Q Then dropping down to clause 2, Licensed or Accredited Hospital, does the plan cover services [2-99] by such an entity?

A By accredited hospitals, yes.

Q Well, supposing it's licensed and not accredited?

A Then it might have to meet another one of the tests under the definition of hospital.

Q Before it could clear?

A That's right.

Q Take a look at Clause 3, if you will, which is referring to, first of all, a community mental health center which is subject to the approval of the Department of Mental Health. Would services by a community mental health center be covered by the GTE plan?

A Yes, they would.

Q Would they always be covered by such a plan?

A No, they might not be.

Q What is the proviso that would have to be applicable in order for it to be covered?

A That the diagnosis and treatment be prescribed by and supervised by a licensed physician.

Q Is there anything in Section 47b that requires a recommendation by a licensed physician before you receive the benefit with respect to community mental health centers?

[2-100] A Yes. They use the word psychotherapist and then define it as meaning a person fully licensed to practice medicine, under the provisions of the act.

Q That's down below, is it not?

A Yes.

Q There's no requirement stating that before you can get coverage for going to a community mental health center you have to be recommended by a psychotherapist?

A No, I don't read that.

Q The next clause or the next entity that's dealt with in the same clause appears to be a mental health clinic. Do you provide coverage for mental health clinics?

A Yes, we do, provided they are affiliated with a hospital.

Q So, once again, you have—you seem to have a series of qualifications and so forth. Sometimes a mental health clinic might be covered, sometimes not, depending on whether there's a hospital affiliation?

A That's correct.

Q The next mental health facility that's referred to [2-101] is a daycare center furnishing mental health services. Does the GTE plan provide a benefit with respect to services in daycare centers?

A I can't categorically answer yes or no. I'm not sure I know what a daycare center is, with respect to mental health insurance. I've not heard the term before.

Q You don't see any definition as such in 47 pages?

A No, it's not defined on what I have in front of me.

Q All right, then. Moving on to services rendered by a psychotherapist as defined in Section 47b, does the GTE plan cover services of this type?

A Yes, it does.

Q Can you elaborate on that?

A By virtue of the definition of a psychotherapist as being a fully licensed—a person fully licensed to practice medicine, our plan requires that the person be a licensed physician. So I can interpret a person fully licensed to practice medicine as being a duly licensed physician.

Q All right, sir. Now, moving on to this one last form of service, namely by a psychologist licensed under a particular chapter. Does the GTE plan provide coverage for services of that sort?

[2-102] A No, it does not.

Q Whether licensed or not?

A That's correct.

Q What are the reasons why GTE does not provide services for licensed or unlicensed psychologists?

A Primarily, it's a problem of definition and qualification. There's several states that have different qualifications for licensing psychologists. Some states have fairly rigorous educational and testing requirements in order to obtain a license and a rigorous test that has to be passed. Other states have that to a lesser degree, and some states not at all. In order to maintain the uniformity of benefits, we've had to provide fairly rigid definitions under the plan so that they apply to all of the employees uniformly. And because of the divergence in several states of licensing practices and qualifications, we find at this point in time we're not able to recognize psychologists as a class under the plan as we offer, for example, licensed physicians because we are familiar with what a licensed physician is and the requirements to become a licensed physician.

Q Stepping back a minute, Mr. Hyland, based on your [2-103] duties as Vice-President of Insurance and so forth, would you tell us what effect do you see a stat-

ute such as 47b and others like it having on your GTE health plan, on the administration of it?

A It would severely complicate the administration of the plan in that, if we're dealing with fifty-one jurisdictions, we would have to have at least fifty-one variations to a single plan. The problems in administration would then be multiplied perhaps not be fifty-one but by a significant factor.

Q Whatever number it is, it's—

A It's more than it is now, yes.

Q —undercutting the uniformity you now have?

A That's correct.

Q What else?

A We think it would probably lead to severe employee dissatisfaction that we had experienced in earlier years that we endeavored to overcome by designing a comprehensive package of benefits that we now have that the employees can enjoy. If we had divergence of benefits from one state to the other, we would simply lose the benefit that we arrived at [2-104] by having a uniform plan.

Q What about administrative costs?

A They obviously would go up. The more complex you make the plan, the higher degree of expertise is required to administer the plan, so we would immediately required higher talented, hence higher pain employees, and if you multiply the complexity by the numbers of units as in the fifty-several states, you then have to add additional staff of that caliber in order to cope with the various divergencies between the several states.

Q What would be the effect on the level of benefits available for employees?

A One of the effects is that the level of benefits would not increase at a rate that is desirable to keep the plan competitive with our employees and for the benefit of the employees. If the level of benefits had to increase, then some other area of the wage benefit package would have t. be reduced, such as cash wages or possibly a

holiday would have to be give up or some other benefit. There's a cost trade-off somewhere.

Q I'd like to focus a little more on one of those effects you just mentioned, namely the effect of [2-105] this statute and others like it on GTE's administrative costs. Can you explain more fully to us the types of administrative problems that these statutes would raise that produce more time, most costs, more error and that sort of thing?

A Yes. The mere complexity of having to deal with fifty sets of criteria, if each of the states took similar action, would require a person who was familiar with first the requirements of the several states. We'd have to inquire of the employees where his residence—of course, we know where the employees reside and where they work—if it's a claim for the employee's dependents, where they reside should there be a difference between the states between which the employee is working and residing and if one state on one side of the border may provide benefits for residents where the one across the border may require or provide benefits only for people who work in that state.

Q Before we get into that, let me backtrack with you for just a minute. Before the problem that you have in determining the eligibility, and that sort of thing, is there a problem about finding out [2-106] what the laws are as you go along week after week?

A Well, more surely there is. At the moment, we're operating under the federal statute, the ERISA statute, and we can identify that and know how to operate under that comfortably now. If we were subject to fifty different laws with respect to employee benefits, we would then need legal counsel in fifty of the several states, for each of the several states, in order to keep us up to date with respect to the changing benefit requirements of those states.

Q Let me digress just a minute, less than a minute. Do you have a savings investment plan?

A Yes, we do.

Q What is it anyway?

A The savings investment plan is a matching contribution plan whereby the participating employees contribute a portion of their salaries and the company matches fifty cents on the dollar for each dollar that the employee contributes. And at the moment, the employee may invest his contributions in either GTE shares, into a shares fund, an index fund, a bond fund, or a guaranteed income contract.

Q Maybe I'm using the wrong term, but don't you have [2-107] a plan where the employee is enabled to borrow money—

A No, this is the same plan we're speaking about.

Q Is that plan subject to the laws of only one state?

A Yes, it's the loan provision that you're making reference to. We're amendnig the plan January 1 of 1981 to provide or enable the employees to borrow funds from the plan, as opposed to have in-service withdrawals and incurring penalties. When we were designing this loan provision of the plan one of the first questions that was raised were what usury laws would we be subject to, and the instructions I was given by my supervisors were that, if we were subject to the usury laws of several states, to forget the benefit; that we would not go to the expense to provide the administrative procedure to keep up to date with all of the usury laws.

Q It turned out you're going to have this plan because there's just one single law?

A Yes. Now that we've obtained opinion of counsel that because the trust is domiciled in Massachusetts and the loan is going to be made in [2-108] the State of Massachusetts, that we're subject to Massachusetts banking laws and having, now being subject only to one state banking law, we're proceeding to introduce that benefit. And we'll have that on January 1.

Q Getting back to health benefits again and away from the digression about the somewhat similar situation of this other plan and what would happen if you had a series of conflicting laws, you mentioned the monitoring difficulties and costs. Now, I'd like you to talk a little more about the additional difficulties and costs that would be associated with determining eligibility, dependents, residents, where you work, divorces, this sort of thing.

A The way the states thus far, to the extent that I'm familiar with the few states that have enacted such legislation, define eligibility is various. Some states define a person is eligible for a mandated benefit as being employed in the states, others residing in the state, and others residing or employed, and still others possibly employed and residing. The first thing that would have to be determined when a claim is received by [2-109] the claim clerk is to determine if the employee is eligible to receive benefits under that claim. Where we have the divergence of definition of eligibility, the claim clerk is then going to have to inquire as to the residence and employment status of the employee or his dependent, and then apply the correct interpretation to the state statutes that apply in order to determine under which statute he may be eligible to receive the benefit.

Q As you complicate the form and as you complicate the claims handling procedure, what happens to your error ratio?

A It obviously would have to go up.

Q What happens to the necessity to instruct your claims handling personnel?

A The higher degree of training required, a higher degree of instruction required and a higher degree of supervision required to assure, as best you can, a low level of error factor.

Q What effect cost-wise does this kind of mandatory statute and others like it have on the task that the company has of informing employees of their benefit rights?

[2-110] A As Mr. Morris testified, we're required under the Pension Reform Act to provide every plan participant with a summary plan description which is a layman's version, if you will, of the summary of the salient features of the plan. We now print a summary plan description of our plan which is Exhibit 17. The way we physically produce the summary plan description is everything is printed. One shot and it's all the same. The only difference being, again, the cover, the same as we do on our union contract. So we're able to produce—in fact, last year we were able to produce half a million of these, 500,000 of these summary plan descriptions, but it was a one set-up and then print 50,000 (sic) of them. The cost is approximately $3 for one of these booklets. If we were to produce, for example, 50—if we had fifty several states with such enactment—the cost would be increased, we're guessing, to approximately $5 a book. There is the possibility of not printing fifty different versions of the same booklet with the state exceptions but print one booklet and then have in the back, for example, a state exception sheet. We find that would be undesirable from an employee's [2-111] point of view in his ability to understand what his benefits are because you would be explaining the benefits in the front and have possibly taking them away in the back, which is contrary to proper communication.

Q In terms of this company's experience in the 1950's and 1960's, how would you characterize overall, the effect of this Massachusetts statute and others like it on the GTE plan?

A Well, the effect is to bring us back to where we were in the 1950's, with a multiplicity of plans not necessarily having a relationship one to the other, which would generate increased costs and severe employee relations problems.

Q From your standpoint, its turning back of the clock?

A Yes, it is.

MR. MC GOVERN: No further questions.

THE COURT: Let me ask you this, sir, if congressional policy—the Congress of the United States, in other words—if their policy changed to the extent that there was a national congressional health policy similar to our statute, the Massachusetts statute, included in [2-112] ERISA, okay, would that be troublesome to you?

THE WITNESS: No, sir.

CROSS-EXAMINATION
BY MR. MONTGOMERY:

Q Just to follow up on the Judge's question, Mr. Frank (sic), is it fair to say that you're not opposed to mandated benefits, just to diversity of the requirements of the mandated benefits?

A That wasn't his question.

Q I understand that. I'm asking a different question.

A No, no, I'm personally not opposed, nor is GTE opposed to mandated benefits to the extent that they're reasonable and are socially desirable and for the benefit of the community as well as the employees. I think there's a resistance to mandated anything, benefits or otherwise. We at GTE like to pride ourselves, and I personally, individually pride myself in not having to be told what needs to be done but rather taking the initiative and doing it with the spirit of the free enterprise system, if I may.

THE COURT: I've asked a question, which I think is the first time I've asked a question—it may be appropriate—we'll take a [2-113] short recess, five minutes.

(Recess)

Q Mr. Hyland, I just want to clear up one possible discrepancy from your direct. You did testify, I think, that the exhibits marked as 12, 13 and 14, the collective bargaining agreements, were standard for all employees but the covers are different.

A All employees who are covered by that union contract.

Q But there are differences for, you mentioned, for holidays and things of that nature?

A There are differences on the local level, in dealing with the local.

Q And are these contained in the documents that are marked as Exhibits 12, 13 and 14?

A Yes. The differences that apply to the Long Avenue plant are in those particular ones. The ones that would apply to the Ipswich plant would have possibly variances with respect to holidays and things of that nature.

Q And holidays is an example of the kind of benefit [2-114] under the agreement that would vary from state to state?

A Yes. In fact, they might vary from plant to plant and community to community.

Q You also mentioned lunchroom facilities as a variation. Would you elaborate on that, if I'm correct in my recollection?

A Yes. Some plants have lunchroom facilities, others do not. Where lunchroom facilities are provided the employee, in some cases they're subsidized and others not. And in particularly the case of subsidies for the lunch or cafeteria facilities, sometimes those are bargained.

Q Are you familiar with any state or local laws in any state of the country which require lunchroom facilities?

A I'm aware of the existence of such laws. I'm not familiar with any of them.

Q But, would it be fair to say the individual agreements would comply with those various state and local requirements?

A Yes.

Q Are there any other variations besides holidays and lunchroom facilities that may differ from [2-115] bargaining unit to bargaining unit or state to state or plant to plant?

A Yes. Work rules—

Q What do you mean by "work rules"?

A How many employees are to be employed on a particular line. For example, what the bidding process is for first-line supervision or for another job. It could be any variety of different work rules. Sometimes, well, there's a variety of them.

Q Now, do you know what percentage of the premium, the total health care package premium, is attributable to claims for treatment for mental or nervous conditions?

A I can tell you the number. The premium this year is approximately $200 million. The premium for outpatient mental and health services is $2½ million this year. So, what is that, one-tenth of 1 percent, or 1 percent?

Q 1 percent.

A 1 percent.

Q Now, in the course of your duties as Vice-President for Insurance are you familiar with Worker Compensation laws?

[2-116] A Yes, I am.

Q Would you explain briefly how the worker compensation system works nationally?

A There is no national worker's compensation system. Several states have jurisdiction over worker compensation laws within those states.

Q And do you have, does GTE have a relationship with a particular insurance carrier?

A Yes, we do.

Q Is it one carrier?

A One carrier provides all of the worker's compensation benefits, except in those states where a state fund is mandated.

Q And how many states do not mandate a fund and therefore require you to insure your worker compensation benefits?

A Well, there's eight states that mandate it, so there'd be forty-two states and the District of Columbia that do not.

Q And you have one carrier for those forty-two states and the District?

A That is correct.

Q Who is that carrier?

A It's Lumberman's Mutual Insurance Company—[2-117] Lumberman's Mutual Casualty Company.

Q Do you have a single policy with Lumberman's Mutual?

A Yes, we do.

Q And does that policy comply with the individual requirements of each of the forty-two states plus the district?

A Yes, it does.

Q And how does it do that? The benefits obviously vary.

A With a great deal of difficulty, I'd say. The policy is a single policy, and it has attached to it the state exceptions. Each of the state exceptions is larger than the policy itself, so that emerging policy is literally about 6 inches wide. It takes up two three-ring binders. The administration of the worker compensation benefits are not overly complicated in that we can always identify the employee's workplace, so we know in most cases what jurisdiction applies in a worker's compensation injury situation. What complicates the situation is the variance of benefit from one state to the next and the application of such benefits. It does give rise to inequities between [2-118] one employee and the other, which is a situation that we simply have to explain to the employee that that's just the way it is.

Q And for how long has GTE provided state specific benefits in those forty-two jurisdictions plus the district on the worker's compensation?

A Since worker's compensation statute were enacted in each of those states.

Q And how long has that—well, I guess you couldn't state for each of those states—

A It was before I was born, I can tell you that. And it's more than fifty years.

* * * *

[2-120] Q Now, do you know how many states currently mandate the inclusion of mental health benefits for treatment of mental or nervous conditions in group insurance policies?

A I know of three and I suspect a fourth and there may be, perhaps, fifteen or twenty.

Q Now, are the three with which you're familiar, do those statutes require that the benefits be provided for contracts—extraterritorial, for contracts issued outside of the state covering in-state workers and residents?

A Two of them do, and the third one, I'm not certain.

Q So that it would be your understanding it would only be those two statutes that the company would be required to comply with, with respect to any policy not issued within those two states?

[2-121] MR. MC GOVERN: Excuse me. Objection. I think he was not certain of the other one.

THE COURT: I agree with you. I think he was not certain.

Q Maybe we could identify the states. What are the two states that you are certain?

A Maryland and Massachusetts.

Q Would it be fair to say that the only current problem presented for the GTE plan by the mandated benefits statute are presented by those statutes that have an extraterritorial effect?

A No, that would not be fair to state that.

Q Why not?

A Well, the extraterritorial effect is not the most complicating issue. The more complicating issue is the—may I ask, perhaps, to clarify what we mean by extraterritorial? Do you mean extraterritorial, as respect to the contracts issued within and outside of those states?

A Yes. In other words, there are—correct me if I'm wrong—there are statutes which provide or mandate

minimum mental health benefits but which do not apply, which apply expressly only to contracts issued in that state?

[2-122] A Yes. With respect to contracts issued within or outside of a particular jurisdiction, doesn't present me with a particular problem because it doesn't affect the delivery of the benefits within the state.

Q That's right. So that your answer to the question would be that the problem—you talked about problems of administration, and I'm just trying to make sure that your testimony is clear. The current burden imposed by mandated benefits statutes is only imposed by those statutes, however many there are, that have what we call an extraterritorial effect?

A Yes.

Q Now, do you have any actual data, any studies that you performed that would indicate the extent of the administrative burden that is imposed by that statute, by those statutes?

A No, I do not.

Q Do you have any data that would indicate the extent of the total administrative costs of the GTE health plan?

A Yes, I do.

Q What is that?

[2-123] A The cost is—

Q What percentage or dollar figure?

A The cost is approximately 6 percent of the premium.

Q Now, with respect to that portion attributable to administrative costs, what further portion is attributable to costs of administration for claims for treatment of mental and nervous conditions?

A I'm sorry, I don't know that. For a fast answer, we would simply prorate the claims which we do know over the cost and say that's it, but we don't know that that's it or not. As a matter of clarity, if I may, GTE does not administer the plan; the Travelers administer

the claims for us, and they charge us at the rate of 6 percent of the premium for that administration. So it's their administrative expenses that we're addressing.

Q A couple of more questions, Mr. Hyland. You're familiar, are you, with the federal statute which requires employers to provide for pregnancy-related disabilities on the same basis as other disabilities?

A Yes, I am.

[2-124] Q And are you aware that prior to the effective date of the federal amendment to Title VII last year that there were various state requirements—

A Yes, I am aware of it.

Q —mandating those benefits?

A Yes, I am.

Q Are you aware of a particular Massachusetts requirement in that connection?

A No, I'm not.

Q Prior to the effective date of the federal statute, what was the extent of benefits provided for pregnancy-related disabilities in the GTE plan?

A We provided no disability coverage with respect to maternity.

Q And I assume that now you do provide those benefits in accordance with the federal statute?

A That is correct.

MR. MONTGOMERY: Thank you. No further questions.

THE COURT: You had no benefits at all?

THE WITNESS: For disability. We provided medical reimbursement for obstetrician and hospital, but no loss of wages.

THE COURT: Thank you very much.

[2-125]

REDIRECT EXAMINATION
BY MR. McGOVERN:

Q Mr. Hyland, at the outset of your cross-examination, you said something to the effect that you weren't against or weren't opposed to mandated benefit laws, except that you do have a reservation that you would prefer to do these things yourself. Do you recall saying something to that effect?

A Yes.

Q When you were talking about this reservation, were you thinking in any sense of the collective bargaining process?

A Most specifically in respect to the collective bargaining process.

Q Can you explain just exactly how important that reservation is?

A Yes. We bargain in good faith with the employees who are represented by a collective bargaining agent. And we don't attempt, and never have, nor will we, to impose upon those employees a benefit that they have not, in fact, bargained for, nor, obviously, will we take a benefit away from them. It's important to us as employers, and I think equally as important to the employees, as members of this collective bargaining arrangement to come [2-126] to an agreement on the benefits and wages and working conditions and everything else that are part of the bargaining contract. I think—while I've never belonged to a union—I suspect that employees who do belong to a union feel a certain amount of pride with the thought that they may have something to say about their own destiny and about their own employment through the bargaining process. So that primarily is an important thing that should be left to the free enterprise system, if you will, private bargaining between people who know what they're doing.

Q This is the area reserved for the collective bargaining process?

A Yes, it is.

* * * *

[2-128] Q Mr. Hyland, very recently, has there been a presidential commission to study the operation of the Workman's Compensation laws in America?

A Yes. The President convened a commission called the President's Commission on Workman's Compensation, appropriately enough, in 1974.

Q Have the inequities of the way these compensation laws are working out for employees, did that have anything to do with the establishment of that commission?

A That was the primary motivation of the establishment of the commission.

Q Have the costs and the inefficiencies of the program as it's working out, was that a subject matter of that commission?

A Yes, it was.

* * * *

[2-131]

[TESTIMONY OF JOHN G. LARSON]

DIRECT EXAMINATION
BY MR. GREENFIELD:

Q Will you please state your name and address?

A My name is John G. Larson. My address is 10400 Melissa Mill Road, Richmond, Virginia.

Q Could you give us your academic background starting with college?

A I graduated from the University of Richmond with a Bachelor's of Science in Business Administration. I received a Master's in Hospital Administration from the Medical College of Virginia. And I received a Ph.D. in Health Administration from the University of Manchester in Manchester, England.

Q When did you receive your Ph.D.?

A 1975.

Q What is your present position?

A I am currently an Associate Professor in the Department of Health Administration at the Medical College of Virginia, Richmond, Virginia.

Q Have you published any studies in the area of mandated health insurance coverage?

A Yes, I have. I have published a study called Mandated Health Insurance Coverage, a study of review mechanisms.

Q And when did you publish that?

A This was released in 1979.

Q At whose request did you publish that?

A I conducted the study for the Bureau of Insurance in the State of Virginia, really at the behest of a commission called the Health Care Cost Containment Commission in the State of Virginia. The Bureau of Insurance was acting under the direction of this commission and the Bureau of Insurance requested [2-134] that I do the study.

[2-143] Q Now, in the course of preparing your report did you formulate any opinion as to the cost of mandated benefits for covering chiropractors in Virginia?

A Yes, I did.

Q And is that referred to in your report?

A Yes, it is.

Q Is that referred to in approximately pages 35 and 36?

A Yes, I believe it was on page 35 that I make the statement of trying to get an estimate of what the cost is in the State of Virginia. The reason I did this was there was simply a lack of real accurate or just simply available data. Often in the discussions over the feasibility of a mandated [2-144] benefit, cost impact is constantly brought up. Too often, the figures are provided as simply, as you will see on page 35, as an estimate of what the monthly increase might be for a single policy holder. For instance, they stated here in the State of Colorado it was $.26 per month.

Q You're referring to page 36 here?

A Right. Also, it's stated on page 35. What I tried to do was to demonstrate the magnitude to the entire state, or if you like, those who have to pay the bill, meaning employers or employees, of what the entirety might be, the total impact of just a $.26 per month premium.

And so simply, what I did there to demonstrate that in a very crude fashion, but the only way available really, was to multiply that $.26 times the number of Blue Cross Blue Shield subscribers in the State of Virginia. That yielded a figure of approximately $11 million annually. That did not include those covered by commercial insurance. I merely used Blue Cross plan subscribers because I was essentially using a Blue Cross plan figure, if you like, in Colorado. It's a very crude estimate, but again, trying to give an estimate of the totality of the impact. [2-145] Q Now, you did it by figuring out the cost of the particular benefit per individual within the group referred to?

A Which is given on page 36.

Q So the answer to my question is yes?

A Yes.

Q And then you multiplied that by the number of people within that group?

A In the State of Virginia, yes.

Q And you said in your report, you said on the stand that it's a crude estimate?

A Yes.

Q Is there any way to come up with a better estimate?

A Yes, but the data's not available.

Q I mean on available data is there any way to come up with a better estimate?

A Not really, no.

Q And while it's a crude estimate, is it a conservative estimate?

A Yes.

Q And that conclusion about the $11 million to cover chiropractors for Blue Shield and Blue Cross subscribers in Virginia, that was submitted to the legislature? [2-146] A Yes, as part of this—it's contained with this report.

Q Now, could you explain in somewhat greater detail what is contained on page 36 of the report?

A Page 36 is an itemization of various mandated benefits or types of mandated coverage. This again are

the figures submitted to me by the Colorado Blue Cross plan. It simply breaks down what would be the additional monthly premium expense for each of these benefits, and, again as you will see there, page 36, it also categorizes it according to individuals or single premium versus family. There's approximately I believe sixteen benefits there.

THE COURT: Approximately what, sir?

THE WITNESS: Sixteen benefits, I believe, are listed there.

Q Would you turn to page 94 of Exhibit 18, Appendix C, and would you explain to the Court what Appendix C is? The Appendix itself actually begins on page 95.

A Appendix C is a reference that I used in my study. It is a document that was passed on to me by the State of Maryland. It is a document that was [2-147] prepared by the Blue Cross plan of the State of Maryland, and it's submitted to the Economic Matters Committee in the State of Maryland. At that time the Economic Matters Committee was studying the issue of mandated health benefits. This was simply one document that was prepared I think by Mr. Fred Gloth who I think is Vice-President of the plan, who was the individual who made an oral presentation and then handed this document in with that particular testimony. The document itself simply shows that at that time there were eighteen different health mandated benefits in the State of Maryland which had been passed. Mr. Gloth's document here, or Blue Cross of Maryland, simply itemizes per mandated benefit what would be the incremental or the additional premium expense for each of the benefits.

Q And by the incremental expense you mean the expense to give that portion of the benefit which has not previously been provided by the insurer?

A That is correct.

Q Now, have you formed an opinion concerning the potential cost impact of mandated benefit laws on a nationwide basis?

[2-148] A Yes, I have.

Q On what is that opinion based?

A Well, one opinion I have clearly is that there will be a continual expense—

Q No. The question was: On what is that opinion based?

A On the data, particularly in my study, the attendance at various legislative hearings that I have participated as an expert witness, hearing other experts testify in terms of their experience as employers or insurers, and I guess the review of documents, and so forth, that I've had a chance to see.

Q And by the data, are you referring to the Colorado data that's set forth on page 36?

A Yes.

Q And to the Maryland data that's set forth at the beginning of page 95?

A That's right.

* * * *

[3-19] Q Now, based upon your review of the report to the Virginia Legislature, Exhibit 18, and based upon your review of the Factbook and, in particular, those pages identified, and based upon your review of the two Sourcebooks and, in particular, those pages [3-20] identified, based upon your review of the literature related to mandated health benefits in general and based upon your review of the literature relating to health costs and based upon your review of the literature relating to the cost of mandated health benefits, in particular, and based upon the research you conducted in preparing Exhibit 18, based upon your interviews with insurers, providers and employers, Blue Cross and Blue Shield, and based upon your attendance at various legislative hearings concerning mandated benefits, have you formed an opinion concerning the potential cost impact of mandated benefit laws on a nationwide basis?

A Yes, sir.

Q What is the magnitude of that cost impact?

MR. MONTGOMERY. Objection.

THE COURT: What's your objection?

MR. MONTGOMERY: Your Honor, it strikes me that the question is being what mandated benefits, mandated benefits where? Generally, the question is insufficiently precise to generate an answer that's really relevant to the case.

THE COURT: I think it's a perfect [3-21] question. It couldn't have encompassed much more, unless he wanted to encompass part of the building. It's a fine question, well prepared, and he can have it. You can answer.

A Yes, I have formed an opinion.

Q And what is that opinion?

A My opinion is that the nationwide impact of mandated benefits could be within the range of additional premium expense on a national basis of somewhere in the realm of $2 billion or up to $5 billion dollars.

Q Now, could you describe in general the methodology that you employed in reaching those figures?

A Yes, sir.

Q Would you please do so?

A Yes. What I did was, first of all, take additional premium expense that was provided to me in the course of my study for the State of Virginia, that is on pages 97 to 100, that gives what was the documents submitted by the Maryland Blue Cross organization that gave additional premium expense for a number of mandated benefits. And on page 36 of my study, again, there is a list that was submitted to me by the Colorado Blue Cross plan [3-22] that gave a list of additional premium expense per a number of mandated benefits. What I did with each of those sets of figures was prepare two separate estimates of the potential national cost impact and simply multiply those figures times figures that I derived from the two Sourcebooks and the Factbook and multiplied those additional premium expense times national group enrollment figures, that is, for health insurance, purely group enrollment. What I tried to do was eliminate individual policies and any self-funded programs so I could come up with a pure figure, if you like. The reason I did that is primarily that mandated benefits

are more likely to impact on group enrollment programs and not so much because the laws do vary in individual programs and at the same time make it a conservative estimate—be as conservative as possible in terms of keeping it right down to pure group enrollment figures for health insurance.

Q Now, we'll get into the specifics of your computation in a minute, but the procedure that you described, is that the same methodology that you applied on pages 35 and 36 of Exhibit 18 when [3-23] you estimated for the Virginia Legislature the cost of mandated coverage for chiropractors in that state alone?

A Yes, sir. What I did there for the State of Virginia was to simply take, in fact, one of the additional premium expenses from the Colorado figures and multiply those times the number of Blue Cross-Blue Shield subscribers in the State of Virginia; that was only Blue Cross-Blue Shield subscribers, But, essentially, the same kind of logic I employed there is, in fact, what I have done for the potential nationwide impact figures.

Q Now, I'd like to ask you some questions concerning the analysis that you did with respect to the Colorado figures. That analysis was on the assumption that other states would enact the same mandated benefit laws as Colorado; is that correct?

A Absolutely.

MR. GREENFIELD: I'd like to mark as Exhibit E for Identification a table—I'll set up a chart—a table entitled, Nationwide Additional Annual Premium Costs of Mandated Benefits, based on the Colorado Experience of Blue Cross-Blue Shield.

(Table, above-referred to, marked Exhibit E for Identification)

[3-24] Q Now, focusing on the Colorado data which appears in your report to the Virginia legislature, would you describe the analysis that you performed in reaching your opinion relating to the nationwide cost of mandated benefits?

A Yes, sir. If I could refer to the display you have over there—

Q And that is Exhibit E for Identification.

MR. GREENFIELD: May we stipulate that?

MR. MONTGOMERY: Sure.

A Okay. The item A there, which shows a dollar figure of $91.80 is simply taking from page 36 in my study, taking the additional—adding up all the additional premium expenses for the sixteen benefits under the single or if you like individual column. Those were monthly additional premium expenses, so I simply took the total of that and multiplied it times twelve, and that is where you get the $91.80.

MR. GREENFIELD: Does your Honor have page 36 of Exhibit 18?

THE COURT: I just looked at it a few moments ago. Do you want to refer to it again for some reason?

[3-25] MR. GREENFIELD: No, I want to make sure that it's clear. I think it is clear what was done.

THE COURT: Yes.

Q You added up the figures on the lefthand column which was the individual costs—

A That's right.

Q —and that was the monthly additional premium?

A Right.

Q And you multiplied that by twelve?

A To get an annual figure.

Q Why did you use that column instead of the column next to it for family costs?

A Well, I was attempting to be as conservative as possible because I'm trying to get a nationwide impact figure and I wasn't always sure whether the family figures may risk overstating it, so I figured that the best thing to do was simply use the lesser number, the individual policy holder.

Q Had you used the other number, the figure would have been higher, correct?

A Absolutely.

Q Now, would you go ahead and explain the [3-26] computations insofar as they relate to the Colorado data?

A Yes, sir. I took the A figure which is the $91.80 and B is the number of individual employees nationwide with group hospital coverage. The reason I have individual employees as the key word is because, again, the premium that was presented in A, that figure essentially is related to a single policyholder or another way of saying that is an individual policyholder. So, I wanted to use, if you like, the enrollment figures to be like or similar to where the dollar figures are derived. So, what I did there with the help of the two sourcebooks and the factbook derive a figure of number of individual employees under a group enrollment program, under both commercial insurers and Blue Cross-Blue Shield organizations. As I stated a little earlier, at the same time that figure represents a deletion of those persons covered as individual policyholders as opposed to group policyholders. I'd also deleted self-insurance programs, or another way of saying that is ASO's, which give the $55,015,000 nationwide enrollment figures.

[3-27] Q And in doing that you used what was previously described as the sourcebooks and the factbook?

A Yes, sir.

Q Go ahead. I interrupted you.

A C is nothing more than a combination of multiplying A times B, that premium amount, the $91.80 times the estimate of group enrollment with hospital coverage, the $55 million, which yields a product of about $5 billion dollars.

MR. GREENFIELD: Your Honor, I would like to offer Exhibit E into evidence.

MR. MONTGOMERY: No objection, your Honor.

THE COURT: That will be Exhibit 22.

(Document, above-referred to, marked Exhibit No. 22)

MR. GREENFIELD: I'd like to mark as Exhibit F for Identification a table entitled, Nationwide Additional Premium Cost of Mandated Benefits, and says directly

underneath that, Maryland Experience of Blue Cross and Blue Shield.

(Document, above-referred to, marked Exhibit F for Identification)

Q Now, utilizing Exhibit F and focusing on the [3-28] Maryland data in your report to the Virginia legislature, would you describe the analysis that you performed in reaching your opinion relating to nationwide costs?

A Yes, sir.

Q And would you do so, please, now.

A What I have done there in the chart—if I can refer to the chart over there—is based on in my report pages 97 to 100, and those pages are the document that was submitted by the Maryland Blue Cross to the Maryland legislative group. What was contained in that document was eighteen mandated benefits that had been passed in the State of Maryland, and along with that was a figure for additional premium expense for each of those items. They stated in the document, which is A on your display there, that the additional premium costs under the Blue Cross or hospital coverage was $23,500,000.

Q That's within the State of Maryland?

A That is correct.

Q And that figure came from Exhibit C in your report to the Virginia legislature?

A Yes, sir. On the B is the number of covered persons [3-29] which, again, in that document that the Maryland Blue Cross people had prepared, they stated that the number of covered persons was 1.5 million persons. C—

Q And that again comes from Exhibit C of your report to the Virginia legislature?

A Yes, sir. C is using the figures presented in both A and B. What I was trying to do there was get a per-covered person, or unit cost if you like, for the total of all the benefits according to the covered persons. So what I did there, essentially, is divide A, which is $23,500,000 by B, which is 1.5 million persons, and came out with a

unit figure of $15.67. D was essentially the additional premium cost for medical coverage or within the Blue's language—that's Blue Shield, essentially covering physician or medical coverage. Again, the document states that the additional premium cost was $3 million dollars.

Q That is from Exhibit C to your report to the Virginia legislature?

A Yes, sir. E is taking again the figure of numbered covered persons of 1.5 million and dividing the $3 million by the 1.5 million, which [3-30] yields a unit figure of $2.

Q And that was a per-person cost in Maryland?

A Yes, sir, for the medical coverage.

Q Will you continue, please?

A Yes. The nationwide projection, as I moved down to F, which is—F, first of all, is the number of persons nationwide with group hospital coverage. That again is a combination of individuals with group hospital coverage under the commercial insurers as well as all the Blue Cross-Blue Shield plans throughout this country. That is a figure that I derived from using the sourcebooks and the factbook, coming out with a total of 135,942,000. G is the national additional premium costs of mandated benefits for group hospital coverage. Simply what I did there is taking that number of persons with group hospital coverage, the 135 million, and multiplying that times the $15.67, that unit figure which is C times F. That yields a figure of approximately 2,134,000,000 figure. So that would be a national impact for purely group hospital coverage. Now, I'll move on to H. H is the number of persons nationwide with group medical coverage. That relates, essentially, to [3-31] the Maryland figures the Blue Cross organization, which predominately offers medical coverage or physician's expense coverage, is another way of saying that. Again, I worked at developing a figure that the number of covered persons—that is, covered persons—I should make the distinction, as different from covered employees because covered persons is essentially employees plus their dependents. So there's a greater number. The reason that is different in the two

displays is because the data I had from Maryland essentially dealt with covered persons. That data I had from Colorado was essentially individuals or individual employees, so I wanted to minimize any distortion of that data. So here, I have number of covered persons nationwide with group and medical coverage. Again using the sourcebook and the factbooks, I came out with a figure of 129,308,000. I, the nationwide additional premium cost of mandated benefits for group medical coverage, is essentially multiplying E times H. E is that unit figure of $2 per covered person that I got out of the Maryland calculations, and multiply that times the 129 million which is the nationwide estimate of [3-32] individuals covered by group medical coverage. That yielded a figure of 258,616,000. G is an addition of G, which is the nationwide estimate for group hospital coverage, and I, which is the nationwide estimate for group medical coverage, which gives a figure of approximately 2,388,827,000.

MR. GREENFIELD: I would move Exhibit E into evidence as Exhibit 23.

MR. MONTGOMERY: No objection.

MR. GREENFIELD: Excuse me, your Honor, that was Exhibit F for Identification.

(Document, above-referred to, marked Exhibit No. 23)

THE COURT: There was no objection?

MR. MONTGOMERY: No objection.

Q Could you explain the differences between hospital coverage and medical coverage?

A Yes, sir. Would you like me to explain it?

Q Yes, please.

A Hospital coverage generally refers to the insurance coverage that pays for the expenses of receiving treatment in an in-patient facility or a hospital. It can also be expanded almost, again, it depends on every benefit program of the insurance company, [3-33] but any essentially institutional services or institutional fees that might be provided to an individual.

Q Now, based upon the sources that I previously mentioned, do you have any opinion as to what the nationwide cost of the existing mandated benefit laws is?

A Yes.

Q What is that?

A That existing benefits could be within the realm of that $1.1 billion dollars.

Q And that's in addition to premiums paid without such benefits? That's with the excess mandated?

A That's essentially of existing premium dollars nationally; that would be the amount that could be considered to be the cost of state mandated benefits as an estimate.

Q Now, how did you arrive at that opinion?

A What I used is a figure submitted by the Director of the Civil Service Commission at a congressional hearing in which this individual stated that of the current premium dollar volume under health insurance benefits within the federal employees program, that 5 percent of that volume could be [3-34] considered the cost in his estimate of the cost of state mandated benefits. So what I did there was to go to the sourcebook and find out what was the most current premium dollar volume for all health insurance in this country, which is approximately $23 billion, and multiply that times 5 percent, which is the Director of Civil Service Commission's estimate, which yields a figure of approximately $1.1 billion dollars.

Q Now, have you ever heard the term self-insurance?

THE COURT: I want to make sure I understand the question. What was the exact question, if you would; do you remember the question? I think I have it, but I just want to make sure.

MR. GREENFIELD: The question was, in substance: What is your opinion concerning the existing cost of mandated benefits. And then the second question was: How do you arrive at that opinion.

THE COURT: So the basic question was existing cost, presently, I would assume, of mandated benefits, state benefits.

MR. GREENFIELD: Yes. The earlier [3-35] questions assumed that other states would do what Maryland and Colorado does. This question assumes nothing; it just states the statistics.

THE COURT: The actual statistics, or at least his estimate of them. Okay.

Q Now, have you ever heard the term self-insurance or self-funding?

A Yes, sir.

Q What do they mean?

A My understanding of self-insurance or self-funding is when an employer, or possibly a union takes on the responsibility of—and I assume we're talking about health insurance—that the employer or the union takes on the responsibility of paying for claims within its employee group out of its own financial reserves. Or maybe another way of saying it, simply not going out and buying insurance to cover those claims or expenses of its employees.

Q And I think previously you used the term ASO; do you recall?

A Yes, sir.

Q What is ASO?

A ASO stands for administrative services only. [3-36] Typically, what that refers to is where an employer may be self-insuring or self-funding its health insurance program, and insurance company or possibly even a computer firm will provide the processing services like claims review and claims payment on a, I would assume, a fixed dollar amount.

Q So ASO is essentially self-insurance?

A That's, I guess, in the parlance. ASO normally corresponds with the concept of self-insurance.

Q With insurance companies simply performing administrative but non-insurance services?

A Yes, sir.

MR. GREENFIELD: I'd like to move into evidence, move for admission into evidence, Exhibit 24. The Attorney General has stipulated that this may be moved

into evidence and that he accepts the authenticity and accuracy of the figures. This has made it unnecessary to call special witnesses from Metropolitan.

THE COURT: All right. It may be marked.

(Document, above-referred to, marked Exhibit No. 24)

[3-37] Q Could you explain what Exhibit 24 is, Dr. Larson?

A Is that the document that says Metropolitan Life Insurance Administrative Services Only contracts?

Q Yes.

A What this document is is a compilation of data that was shown to me by Metropolitan Life Insurance Company of the number of new ASO contracts issued over a number of years, and the span of years in this document ranges from 1972 to 1979. Essentially what it presents is an upward trend in the number of new ASO contracts from the year, approximately two contracts to 1979, it shows here, eighteen contracts.

Q Now, based upon Exhibit 24 and the material and research that I previously referred to, have you formed an opinion as to whether there has been an increase or decrease in recent years in the number of employee benefit plans going to self-funded or ASO arrangements?

A Yes, sir.

Q What is that opinion?

MR. MONTGOMERY: Objection.

THE COURT: What's your objection?

MR. MONTGOMERY: Number one, your Honor, [3-38] to the extent that there is a trend, the document speaks for itself. In addition to that, I think that there is no basis, at this point, for believing that this particular witness is an expert with respect to the area of self-insurance of administrative services contracts.

THE COURT: What do you say to that?

MR. GREENFIELD: Let me ask him some questions.

Q In the research that you conducted, both with respect to the Virginia study and subsequent research in

preparing to testify, have you interviewed persons with respect to the trend toward self-insurance?

A Yes, sir.

Q And have you interviewed persons with respect to the trend toward ASO?

A Among the other things that I researched for the study, yes.

Q And at the various legislative hearings that you have attended, has there been testimony concerning the trend toward self-insurance?

A Yes, sir.

Q And based upon those factors which I have just [3-39] mentioned and the earlier factors and Exhibit 28, do you have an opinion—excuse me, Exhibit 24, do you have an opinion as to whether there's been an increase or decrease in recent years in a number of funds going to self-insurance or ASO?

A Yes, sir.

Q What is that opinion?

A There is an increasing trend for employees to turn to self-insurance, ASO contracts.

Q Can you explain how you reached that opinion?

A Well, it was a combination of a number of things. It was a major point that was brought up by employers, and of those employers and insurance companies that I interviewed during the course of my study for the Bureau of Insurance for the State of Virginia. It is a commonly stated fact in particularly the three, as I mentioned yesterday, hearings on the subject that I have personally testified at. It is also based on, again, the data that's exhibited here in Item No. 24 that's submitted by the Metropolitan Life Insurance Company.

Q Now, are you aware of any data of any kind whatsoever, written, oral testimony, interviews, [3-40] anything, are you aware of anything which suggests that there is not a trend towards self-insurance?

A No, sir.

* * * *

CROSS-EXAMINATION
BY MR. MONTGOMERY:

[3-47] Q Would you agree that to the extent that states do mandate particular types of benefits in the insurance policies that it's appropriate that the mandated benefit be properly designed to lead to proper utilization of that particular benefit?

A If the mandated benefit's going to be passed and given whatever the objectives are of such passage of legislation, yes, I think that's very important.

[3-48] Q And would you agree that, for instance, limitations on total recovery are, perhaps, one responsible mechanism that the state could use to limit the impact of the mandated benefit legislation?

A I don't know what you mean by total recovery.

Q That establishing minimums—

A Minimum what?

Q Minimum benefit, for instance, $500, $1,000 a year. For instance, I think you're familiar with Maryland, and I think that their recovery is limited to $1,000 per year per subscriber of the policy.

A Well, I think that pertains to any type of health insurance coverage, not just mandated benefits.

Q So that you would agree that placing that kind of a dollar limit on the recovery when the state mandates a benefit is a responsible thing to do?

A Yes, sir.

Q And how about licensing requirements for providers, would that be an additional limitation on the mandated benefit that would be appropriate in your view?

A That is certainly something that has to be [3-49] considered to assure quality services.

Q Professor, on page 5 of Exhibit 18, you have a chart which lists a series of mandated benefits. One of those benefits which you discuss a couple of times in your report is coverage for new-born care.

A Yes, sir.

Q Do you have an opinion as to why so many states, I believe thirty-seven you mention in your report, have

mandated that group insurance contracts provide for new-born care?

A Yes. There has been a tremendous increase in the cost of new-born care, particularly very sick new-born children, and there has been often cited the instance where a young family would not have adequate insurance to cover those which may be very significant costs for new-born care. That has certainly been one of the arguments made, it's my understanding, at the legislative hearings.

Q Do you believe that the insurance mechanism as it exists in this country, aside from these mandated benefit provisions, has provided new-born care?

A Some insurance companies have; some have not.

[3-50] Q In general, has it been provided? Is it available for most people?

A If they choose to buy it, yes.

* * * *

[3-53] Q Now, assuming for the time being that these, what I think on page 5 you referred to as estimates, reflect actual costs, assuming that for the moment, I'd like to ask you whether you are familiar with the distinction between added costs and shifting costs?

A I'm not sure. I'd need for you to define those for me.

Q So, you're not familiar with those two concepts in economic terms, added costs versus shifting costs?

A Like all terms, they're always roughly used by everyone; it's a little dangerous to assume that.

Q Do you know prior to the mandated benefit, sixteen mandated benefits in Colorado, what the total direct costs in that state were for providing the benefits which are mentioned in those sixteen provisions?

[3-54] A I'm not sure what you mean by direct cost.

Q Well, let me get a little more specific. I'm referring to page 36, which start with chiropractor services.

A Yes.

Q Prior to the time that chiropractor services were covered by the Blue Cross-Blue Shield plan, is it fair to

assume that chiropractors were offering their services to residents of Colorado?

A I would say probably it's fair to assume.

Q And is it fair to make a similar assumption with respect to each of these benefits, that these services were being offered, purchased and paid for in the State of Colorado?

A I don't really know that one way or the other. It might be a safe assumption, but I don't honestly know.

Q Okay. Well, let's assume that to be true for the moment. Assuming that to be true, I will ask you whether you know or have you any data with respect to the total expenditures by the residents of the State of Colorado for all of the services which underly these sixteen mandated benefits—prior?

A I don't know of, no.

[3-55] Q Now, would you agree that the—Professor, did you draw a conclusion as to the total cost in Colorado of these benefits? I'm not sure I see that.

A I'm not sure what you mean.

Q Did you perform a projection in Colorado similar to Exhibit 22?

A In other words, premium expense times the number of enrolled persons?

Q In Colorado.

A No, sir.

Q Okay. Would you agree that had you had done such a calculation that it would only represent the additional—it would only represent premium costs for those services?

A Yes, sir.

Q And that to some extent that premium cost would represent a shift in the nature of payment for those services?

A What do you mean by that?

Q Well, previously the services were provided, and now they're being provided but paid for by a different source.

A I'm sure there's some shift; I don't know the exact [3-56] magnitude.

Q You can't distinguish, with respect to Colorado data, the shift in cost from additional costs?

A No, I don't know that, no.

Q But would you accept that there's going to be some shift and some addition?

A Not entirely. I'm having a problem with your question and let me just tell you why. Because, very often these types of services are provided under other forms of insurance, so I just don't know what the array of benefits of this Blue Cross organization, you know, in detail offered. That's why I'm having a problem with the question.

Q That's an interesting comment. Do you know the extent to which these benefits were provided by other forms of insurance prior to the state mandate for group insurance contracts?

A Well, I'll give you an example. You see, very often these mandated benefits may simply mean to pay the practitioner on an independent basis. But very often, under maybe a hospital coverage the insurance company was paying for it because the practitioner was part of some sort of health service or hospital service, and the only difference [3-57] is they've moved from the domain to be independent practitioners. You know, the magnitude of the shift, there's so much unknown there that I don't know.

Q Okay. So that when you talk about additional premium cost, you're only talking about additional premium costs for group insurance policies?

A No. But it could cost more money because the practitioner is practicing independently as opposed to a provider group formally, so it may be a shift and an addition.

Q Okay. But with the example you just gave me, prior to the statute, he was being paid through the insurance mechanism; subsequent to the statute, he was

being paid through the insurance mechanism; isn't that right?

A But he may be paid more.

Q Okay.

* * * *

[3-63] Q Professor, I'm referring to page 12 of Professor Samuelson's text on economics, in which the fallacy of composition is defined as, "a fallacy in which what is true of a part is, on that account alone, allegedly to be also necessarily true of the whole. Very definitely, in the field of economics it turns out that what seems to be true for individuals, is not always true for the society as a whole." Referring now to page 566, another reference to the fallacy of composition, and quoting from the fourth paragraph: "What is true for a small sector of the economy need not be true for the whole aggregate." Do you recall now having heard this definition of the fallacy of composition, what it is?

[3-64] A Generally, sure. It's been a long time since I've seen it.

Q Do you think that the fallacy of composition has any relevance to the cost projections that you've made in Exhibits 22 and 23?

A I'm so unfamiliar with the concept and read the book, I wouldn't want to hazard a guess.

Q Well, you think that it's important in making a projections of the type that you have to examine the underlying market for the services which are the subject of the projection?

MR. GREENFIELD: I object as to form. I don't know what that means.

THE COURT: I honestly don't either. Can you rephrase that; I didn't understand it myself.

Q I'll try again. In making the projections that you —the type of projections that you made in Exhibits 22 and 23, do you think that it is important to examine the demand for the services represented by the projections?

A To have a more accurate projection, sure.

Q And have you performed any analysis of the demand, nationwide demand, for the services that [3-65] you project will yield an additional premium of $5 billion?

A No, sir, the data's not available.

Q Okay. So, you don't know whether, in fact, there is a sufficient consumer demand for those services that $5 billion in additional premium would be required?

A No, sir.

Q Now, and, of course, just to state it another way, would you agree that your projection is based upon an assumption—

A Yes, sir.

Q —of sufficient demand?

A Yes, sir.

Q Is your projection also based on an assumption that there is sufficient supply of providers of those services?

MR. GREENFIELD: Your Honor, I'd like to object. We're dealing with mandated statutes which say irrespective of demand, irrespective of supply, you have to offer it. The witness's testimony and his opinion are based on mandated statutes. It has nothing to do with the particular demand or supply because the statute has nothing to [3-66] do with demand or supply.

MR. MONTGOMERY: I'm not asking about the statute.

THE COURT: It's overruled.

Q Professor Larson, in your experience does the premium cost that insurance companies assess for providing a particular benefit have any relation to the demand for the service?

A In my experience—the reason I'm pausing on that is because to give an accurate answer there—obviously, the premium expense has to be some reflection of the use of a service, absolutely, but it's not the total reflection, by no means.

Q Well, what else does it reflect?

A Well, the premium includes things like the profits for the commercial insurers, reserves, administrative ex-

penses; so the premium is not totally just claims experience.

Q Well, Professor, again referring to page 36 in your chiropractor services, and to get very simple, if there were no chiropractors in the State of Colorado—

A Yes.

Q —do you think Blue Cross-Blue Shield would charge [3-67] the same premium?

A That's very difficult—you know, it's a cause and effect. It depends on—

Q Thank you.

MR. GREENFIELD: Let him finish.

Q Would you like to make an additional comment on that?

THE COURT: He probably wants to chat about it. You can continue.

MR. MONTGOMERY: Excuse me for interrupting.

THE COURT: You can continue.

A What I'm trying to say is that very often, by the existence of insurance, often brings about the supply and, so, whether the supply existed before the law was passed or simply the insurance company chose to offer the coverage, often, you know, the demand does not necessarily exist before the coverage provided. Am I clear on that?

Q Yes, I understand. Now, are you familiar with the Colorado statute which mandates a minimum mental health benefits?

A No, sir.

Q You do know, I would assume from page 36, though, [3-68] how much Blue Cross-Blue Shield has projected it would cost to provide that service?

A In terms of projected claims experience?

Q Yes.

A No, I don't.

Q Excuse me, not claims but premium requirements. I think on page 36 you have $1.60 per individual and $3.52—

A That's purely premium expense.

Q Now, do you have a similar cost projection for the State of Maryland?

A Well, I suppose there would be where the benefit was similar, but I don't know which benefits are similar or identical.

Q Well, I'm referring to the mental health, mental or nervous conditions benefit.

A Yes, sir, but I don't know whether the structure of the benefit is the same from state to state.

Q Okay. So that in making your Colorado projection, you assume that each of the mandated benefits would be identical across the country; is that it?

A It would have to be, yes, sir.

Q Now, referring to page 98 of Exhibit 18, isn't it [3-69] correct that Colorado projects a cost of $.70?

MR. GREENFIELD: You mean Maryland?

MR. MONTGOMERY: Maryland, yes.

Q It's $.70 for the mental or nervous condition?

A Yes, sir, that's what's on page 98.

Q Do you have any knowledge of why Maryland was going to charge $7.70 and Colorado $1.60?

A Specifically, no.

Q Are you familiar with the Maryland statute?

A I've read it, but my recall would be next to nil, probably.

Q If we assume that the Colorado statute places no dollar limit on the extent of recovery per person and we further assume that the Maryland statute places a limit of $1,000 per year, would you be able to form an opinion as to whether those two distinguishing factors would have an impact on the difference in the project premium cost?

A Are you saying the benefits are the same in each of the two states?

Q Well, the benefits are the same except to the extent that one is provided, has no limit on the amount that an individual can recover, and the other in Maryland has a $1,000 per year limit. [3-70] The question is: Would that have an impact?

* * * *

[3-72] Q In general, do you believe or from your experience do you have an opinion as to whether the limitations that are placed upon dollar recoveries on a mandated benefit statute have a significant impact on the premium cost?

A Any time you put a dollar limitation, you have to provide some—that has to limit the amount of claims that can be brought against your policy.

Q Okay. Do you have any personal knowledge as to the limitations that have been placed by the Maryland legislature on its mandated minimum mental health benefits statute?

A Nothing I recall, no. It may or may not be, I just don't recall.

Q Now, on your direct examination you mentioned the experience of the federal employees and their insurance benefit program?

A Of the testimony, yes, sir.

Q Are you directly familiar with any of the studies that have been done with respect to the experience [3-73] of federal employees?

A I have seen some, yes.

Q Are you aware that some time ago Congress mandated a provision for minimum mental health benefits for federal employees?

A I just—I'm sure that's true. I just don't know. I don't recall that.

Q Are you aware that there is an optional provision in the federal employee plan which allows each federal employee, qualifying federal employee, to purchase a mental health benefit?

A I just don't know that as a fact. I'm sure it's true, I just don't know that myself.

* * * *

[3-87] TESTIMONY OF THOMAS J. HEFELE]

DIRECT EXAMINATION
BY MR. MONTGOMERY:

Q State your name, please.

A Thomas J. Hefele.

Q Where do you live, Doctor?

A 47 Fairway Drive, Groton, Massachusetts.

Q And where are you employed?

A Psychological Associates of Groton—27 Boston Road in Groton .

Q Thank you. What is your position with Psychological Associates of Groton?

A I'm the director.

Q What is that entity?

A It's a private group practice consisting of non-professionals, five psychologists, three psychiatric social workers, and one psychiatrist.

Q Now, in addition to your position with Psychological Associates of Groton do you hold any other current employment position?

A No other paid employment, but I do have a number of affiliations which bear directly on my practice.

Q Would you please state those affiliations?

[3-88] A I hold an appointment as an Assistant Clinical Professor of Psychiatry at the Boston University School of Medicine. I'm a member of the Medical Dental Staff at Burbank Hospital, a general hospital in Fitchburg, Massachusetts. I hold a courtesy staff appointment at McLean Hospital in Belmont. Those are the affiliations which most directly relate to my actual employment.

Q Would you briefly describe your educational background?

A I have a Ph.D. in Psychology, studies completed in 1969 at the State University of New York at Buffalo, as well as significant post-doctoral studies.

Q And are you a member of any professional associations?

A I'm a member of the American Psychological Association and various divisions of that association. I'm also a fellow of the Massachusetts Psychological Association. There are a number of other professional memberships, but I don't want to bore the Court with a long litany.

Q Do you hold any positions of responsibility in connection with any of the professional associations?

[3-89] A I am currently treasurer of the Massachusetts Psychological Association. I'm also a member of the seven-person committee on professional practice of the American Psychological Association.

Q And have you held any past positions of responsibility in connection with any of your professional associations?

A I have been a member of the Board of Directors of the Massachusetts Psychological Association for several years prior to election as treasurer. I also was chair of the Insurance Committee for the Massachusetts Psychological Association. I would like to backtrack, if I may. There was one item which I neglected to mention in connection with professional employment and affiliation.

Q Yes.

A I am also a paid psychology consultant with Blue Shield of Massachusetts.

Q In connection with your duties as a paid consultant with Blue Cross-Blue Shield, if I might just ask you—strike that question. What are the nature of your duties that you perform as a consultant to Blue Cross-Blue Shield?

A I assist in the development and implementation of [3-90] their utilization review system. Also, I consult with management on various problems and policies in the implementation of the mental health benefits.

Q In connection with your utilization review responsibilities, are those confined to the mental health area?

A Yes.

Q Now, have you published any articles in any professional journals and publications?

A Yes, I have.

Q Would you please, if you can recall, recite some of those publications?

A Well, several of the journals would be: Psychonomic Science and the Journal of Clinical Psychology and the Counseling Psychologist. There have been a variety of presentations at conventions and meetings as well.

Q Could you please briefly describe your practice, your group practice in Groton, please?

A We are a multi-specialty group practice which provides the full gamut of psychological services to persons ranging from very young children to the elderly, treating disorders ranging from mild transient situational disturbance to major [3-91] psychoses.

Q Are you familiar in your professional experience with the various types of conditions which are subject to —mental and nervous conditions which are subject treatment by professional providers?

A Yes, we have dealt with all of them.

Q Would you please categorize or at least list the types of problems that a professional such as yourself would deal with?

A That gets to be a very difficult question to answer briefly. Suffice to say that we deal primarily with persons with neurotic disturbance, a variety of character disorders, situational disturbances and psychoses, as well.

Q Now, in connection with treatment of these various types of problems are there a variety of delivery mechanisms for treatment of mental and nervous conditions?

A Well, there are basically two or three delivery mechanisms.

Q What are they?

A The one with which I am most directly involved and most extensively would be the out-patient [3-92] treatment model. The second one would be the in-patient treatment model, with which I am also involved. And then a third one would be a kind of like, I guess, a partial

hospitalization or halfway house type model, and that I am not involved with.

Q Now, how long have you been involved in your group practice in Groton?

A The group practice itself has been in existence for three years.

Q And how long have you been in practice in Groton outside of the group practice?

A I have been in practice in Groton since late 1974.

Q Now, are you familiar with Section 47b of Chapter 175?

A Yes, I am.

Q If you could, Dr. Hefele, I'd like you to—strike that. Let me ask you, since approximately 1976 has there been any change in the types of problems that you've treated in your group practice?

A Yes. In my own—

MR. GREENFIELD: Your Honor, the witness testified he's been in group practice since '77.

MR. MONTGOMERY: I would strike that [3-93] question. Let me ask the question again.

Q Since 1976, has there been any change in the types of problems that you have treated in the course of your professional experience?

A I have dealt increasingly with persons with significant physical illness.

Q Could you elaborate on your answer and give some examples of what you mean by clients with physical illness?

A I deal with a significant number of people with high blood pressure, tension and vascular headache, chronic pain, significant brain damage, or other forms of neuropsychological impairment, persons with the various concomitance of anxiety neurosis, namely gastro-intestinal symptomatology, nervous tensions—

THE COURT: I didn't get that last part of your answer.

THE WITNESS: The gastro-intestinal symptomatology.

Q Now, what is the difference—I don't think we need to go into any great detail on the nature of those problems—but what is the difference between the range of problems that you described [3-94] as the dominant portion of your practice since '76 and the type of practice you had prior to then?

A Typically, before that it was more a matter of dealing with more traditional neurotic disturbance, depression, adjustment problems.

Q Now, prior to 1976, can you please just explain the source of your client—how did you come by your clients?

A The typical network of referral, you know, somebody knows somebody—

Q Would you explain the types of referrals that resulted in your treatment of clients?

A I really want to kind of hedge on that question; I'm foggy on that. I'd really have to spend a few minutes thinking back, and I'm not sure if I could give you a very accurate answer.

Q Well, let me ask you, has there been a change which you can identify in the source of your clients since 1976?

A I have been increasingly—and this is looking very clearly at the past few years which are the ones, obviously, which are the closest to me—I have seen a very marked increase in [3-95] referrals from physicians.

Q Can you estimate the percentage of your clients who are referred by physicians?

A Within the—I will respond personally, rather than to the whole group practice. Personally, approximately 80 percent of the patients that I see come from physicians.

Q Does that represent any change, any trend?

A That represents a marked change in trends.

Q Can you identify the onset of that change?

A I really can't anchor it at a specific point in time; it has happened gradually over the past three, four years. Certainly, it has happened since the inception of the mental health insurance law. I know one factor there was

that many physicians felt more comfortable referring because they knew then that their patients would be able to deal with the costs of treatment.

Q Now, in addition to physician referrals are there any other referral sources in the course—that you have experienced in the course of your practice?

A I think, if you could name the referral source, we've probably gotten referrals from that source.

Q Let me ask you—

[3-96] A Among those would be hospitals, courts, schools, welfare department, probation officers, local Army base.

Q Let me ask you about referrals, you mentioned a number of referrals from government agencies, from government entitities.

A Yes.

Q Do you know what portion, if you can estimate, what portion of referrals come from government?

A Are you including school systems?

Q Yes.

A 15 to 20 percent. That is—I'm sorry, focusing on the whole practice, it's more substantial.

Q Does that represent any change from your experience, your referral experience, prior to 1976?

A Yes.

Q Do you know the percentage of referrals to the entire group that come from government entities including schools and courts and the welfare department?

A I would like to give you a number that I could have confidence in. I can't give you a really accurate number. I would estimate perhaps 40 to 50 percent, but that is a very rough estimate.

[3-97] Q Can you give a rough estimate of the percentage of such referrals prior to 1976, to you personally?

MR. MC GOVERN: Well, could he lay a basis for this first? I mean, has he seen any records, or this just out of the blue that he's coming up with this? There ought to be a foundation laid before he can make any statements like that.

THE COURT: Was that an objection?

MR. MC GOVERN: It is an objection, yes.

THE COURT: You may have your answer.

MR. MONTGOMERY: I think the question that I had asked: Do you know the approximate percentage of referrals in the course of your own practice prior to 1976, that came from government entities, including the courts, the state welfare department, and the schools?

MR. MC GOVERN: Well, I'm sorry. I thought he was going beyond his own practice.

THE COURT: That wasn't the question I remember either. I thought that the question you asked was framed to elicit an answer as to [3-98] the group practice, prior to '76. That's what I thought you had asked.

MR. MONTGOMERY: If I gave that impression, I apologize, your Honor, because the group practice didn't exist prior to '76, and I really meant to direct it at his personal experience prior to 1976.

THE COURT: Okay. No problem.

A What am I supposed to answer?

Q The approximate percentage of referrals prior to 1976 in your personal practice, that came from public entities.

A I would be hard put to give you a figure at this point. I really have not thought about that.

Q May I ask you if there had been a change since 1976 in that percentage, which I think you said your personal practice was 15 or 20 percent?

A With the marked shift, in that prior to—I go back to 1974-'75, I did substantial contract work for the State Department of Mental Health and the Department of Education. At tha level, virtually all, or very close to all of the referrals at that point were through those public agencies, being paid for through contract funds. Subsequent to [3-99] that, when that dropped off people were then coming utilizing health insurance benefits. Subsequently, there was an increase in referral from various governmental entities, encouraging people to secure treat-

ment utilizing the third-party insurance coverage. And so it's sort of been a swing.

Q Perhaps then I could ask a final question: Has there been a shift in the source of payment for the services you provided to clients since 1976?

A Oh, clearly, clearly and unquestionably.

Q And, could you please explain that change in source of payment?

A I would say 60 to 80 percent of the practice income is from third-party coverage.

Q And prior to 1976, and in your personal experience then, what percentage—

A Perhaps 10 percent was from third-party coverage, if even that much.

Q In the course of treating your clients, is it your regular practice to examine, or did you become familiar with, for instance, their employment and income history?

A Absolutely.

[3-100] Q Would it be fair to say that you've become familiar, in general terms, with the socio-economic class of the clientele that you treat?

A If I didn't, I would be getting a poor history.

Q And since 1976, have you observed any change in the socio-economic class of the patients that your clients—

A I am seeing now, many more working class and lower class people than had been the case in the past. I'm finding them walking into the office with much less trepidation about seeing a shrink, and what that might mean.

Q And with respect to those working class clients that you do treat, what generally is the source of payment for those clients?

A Third-party coverage.

Q When you say "third-party coverage," do you mean insurance companies?

A Yes.

Q Now, in the course of your professional experience, Dr. Hefele, did you have occasion to observe or draw conclusions for each of your clients with respect to the

benefits that they derive from the treatment that you've rendered?

[3-101] A Most certainly.

Q Are there various types of benefits that in your professional opinion your clients have derived from their treatment?

A There are personal benefits in terms of diminishing or elimination of the presenting symptoms. There are benefits to their families. There are benefits to their employers. I think there are benefits to society beyond that.

Q Well, let's take that one at a time. With respect to personal benefits, could you elaborate a little bit more on what you mean by—perhaps you could give an example from your experience of someone who has benefitted personally and explain specifically what you mean.

MR. GREENFIELD: Your Honor, I'd like to object on the grounds of relevance. We are not attacking mental health treatment. We are not claiming that mental health treatment is not to peoples' advantage. Our claims, under ERISA, the N.L.R.A. and under the Constitution, and are not based on the fact that there's something wrong with mental health treatment. We concede that in many cases, it does people good. Our [3-102] claim is under, among other things, under ERISA and the N.L.R.A., is that, at least with respect to what should be mandated and what should not be mandated, Congress has said that those choices should be up to employers and employees. But we concede, at least Metropolitan concedes, that mental health treatment helps a lot of people.

THE COURT: I appreciate your argument. Unfortunately, it's overruled. You may have your questions and answers in this line, by the way.

MR. MONTGOMERY: Thank you. I would be glad to respond if the Court cares to hear.

Q I think the question that was before you, Dr. Hefele, will you please give examples, or give me an example from your personal professional experience, of

the type of benefit that has accrued to a client as a result of the treatment which you gave.

A If an individual comes to me complaining of severe and unremitting pain in the lower back which makes it impossible for him to remain out of bed for more than three or four hours a day [3-103] and after treatment, he is able to get up, move around, go to work and earn money to support himself and his family, then I think it's a rather significant benefit.

Q Have you treated such clients?

A Yes, many times. If he then also manages to have the chronic depression with which he has suffered alleviated, as a function of relief from the pain, then that's a significant benefit.

Q Sir, is there a relationship between pain and depression?

A Yes. It's precisely corrolated—highly corrolated. That's between chronic pain and depression. Acute pain and anxiety bear a strong relationship. Chronic pain and depression are highly related.

Q Are there any other examples that come readily to mind from your personal treatment experience of the kinds of benefit that accrue an individual—

A Well, if an individual has a history of three unsuccessful suicide attempts and continual complaining about suffering deeply with many internal conflicts, and they leave treatment no longer talking about killing themselves, but rather about facing new challenges and feeling good [3-104] about themselves, and going out and being productive, I think that's also a significant benefit.

Q Now, that's a very general description. Have you treated specific persons, residents of the Commonwealth, who have exhibited this?

A Yes.

Q Now, you've also mentioned, in addition to personal benefits, you mentioned more generalized benefits to families. Would you please elaborate a little bit more on what you mean by that?

A To the extent that a family has a very emotionally disturbed member, it has a very significant effect on the mental health and discomfort of the remaining members of the family. To the extent that that person gets better, particularly if it's a parent—father or mother—father, particularly, if the father is the primary wage-earner who is not employed gainfully during the period of the difficulty, there is then clearly a very significant benefit.

Q Now in the course of your practice, have you had an opportunity specifically, to observe on the impact of treatment on an entire family?

[3-105] A Yes.

Q And how would you have that kind of knowledge when you're treating when you're treating one member?

A We do a good deal of family therapy in the context of our group practice. One of the folks who works for me is a highly expert family therapist. We see individuals, couples and whole families quite frequently.

Q Now, in addition to the personal benefits and more generalized family benefits, you also mentioned benefits to the society, a couple of which I think you've mentioned in the course of your examples. Do you have any other—would you elaborate on what you call a social benefit?

A One benefit to society, which I have seen occur repeatedly, is a person who is dependent upon public assistance for support, in view of their emotional disabiilty, finding that it's possible to remove themselves from public assistance and secure gainful employment, contributing thereby to the public through payment of taxes, rather than through removal of revenues from society.

Q And is it possible for you to estimate the number [3-106] of people who you have treated who have, because of their ailment, been on public assistance?

A I would be hard put to do that with accuracy. Suffice to say that there have been a significant number.

Q Now, Doctor, in connection with a couple of your examples, you mentioned both physical conditions and

mental conditions, in the course of the same examples. Is there any relationship between the two?

A Unquestionably, they're quite interdependent.

Q And have you had an opportunity, in the course of your professional experience, to study that interrelationship?

A I've had the opportunity to study that, both theoretically, through formal post-doctoral studies in the field of Behavioral Medicine, and also, to study experimentally, through rather extended practice with the diversity of people with physical and emotional ailments, where I've seen both operate concurrently.

Q Are there any other examples, other than those that you've given, that might further enlighten the Court on the relationship between physical [3-107] illness and mental conditions?

A I could give you an academic lecture that would last three or four hours. I'm not sure you want that.

Q No, I'm asking for a specific example, and you've given a couple already. I just really want to know if there are anymore than would further explain this relationship.

A Well, I can tell you a story of an attorney, if that would help. This was a thirty-two year old female attorney, referred to me by her gastroenterologist for severe colitis condition. In the course of treatment, it became apparent that very significant determinants for the colitis were a rather pressured existence—a type A behavior, to use some of the professional jargon, which were contributing to the lack of opportunity for omission of the ailment. Likewise, there were also some rather significant childhood conflicts which hadn't been resolved, which were putting her into some significant double-bind situations which were creating significant internal pressure. In the course of psychological treatment, both behavioral and insight oriented, there was virtually [3-108] total remission of the gastrointestinal symptomatology and elimination of use of medication.

THE COURT: You're excluding the attorneys that are present here, the lady attorneys; you're not referring to any of them, are you?

THE WITNESS: No.

Q Doctor, you testified that approximately 80 percent of—

A I could tell you the story of an Assistant Attorney General who was very depressed—he has since moved out of state and into private practice.

Q You testified that approximately 80 percent of your practice, or your client population, results from physician referrals.

A Yes.

Q Where you receive a referral from a physician, do you, as a matter of your regular practice, examine both the physical and the psychological and mental history of that patient?

A Yes, quite thoroughly.

Q And to what extent do you examine the prior physical history and treatment of that patient?

[3-109] A I get a full copy of the previous medical record and review that in detail, and where appropriate discuss that history with the referring physician.

Q Now, have you observed in recent, the last two or three years, any change in the nature of the previous physical treatment of patients who have been referred to you by physicians?

A There is less of it, meaning that the referrals are coming sooner.

* * * *

[3-127] REDIRECT EXAMINATION
BY MR. MONTGOMERY:

Q Dr. Hefele, in your opinion do we have an optimum program across the United States for the treatment of mental and nervous conditions?

A No way.

Q In your opinion, are statutes which mandate coverage in group insurance contracts for the [3-128] treat-

ment of mental and nervous conditions an important component of the current treatment approach?

A I believe those statutes are a highly significant step forward. I also believe that in many ways the statutes need to be more elaborate, more extensive.

[3-129]

[TESTIMONY OF GERALD BOROFSKY]

DIRECT EXAMINATION
BY MR. MONTGOMERY:

Q Would you state your name, please?

A Gerald Borofsky.

Q Where do you work?

A I work in a variety of settings. I'm the Director of Psychology at the Eric Lindeman Mental Health Center, which is a mental health, community mental health center operated by the Department of Mental Health. I'm the Director of Psychology in the Department of Psychiatry at Massachusetts General Hospital, and I am a member of a private practice group of psychologists, called Bay State Psychological Associates.

* * * *

[3-133] Q Now, in the course of your experience, Doctor, have you had any occasion to study the different types of costs of mental illness nationally?

A In a very general way, yes.

Q And could you describe the nature of the study that you've made of the costs of mental illness?

A Well, I've been aware of data from the National Institute of Mental Health which shows that there are basically two types of costs for mental illness. There are direct costs, direct patient treatment costs, and then there are indirect costs, such as housing for mentally ill—

MR. GREENFIELD: Objection. Hearsay.

THE COURT: Overruled.

[3-134] A The data also include indirect costs for mental health, such as I say, housing for the mentally ill, plus such things as disability and death-related costs

that result from mental illness. And, I might add that the indirect costs are somewhat substantially greater than the direct treatment costs, the cost to society as a whole.

Q Doctor, are you familiar with the various mechanisms for the delivery of services for the treatment of mental and nervous conditions?

A Yes, sir. There are basically three types of mechanisms, three classes of mechanisms: the in-patient mechanism of treatment, what would be called a transitional or after-care mechanism of treatment, and an out-patient mechanism.

Q Now, in your experience in recent years, have you observed any change in the mix of out-patient and the in-patient treatment in the Commonwealth?

A Yes, I have.

Q And what's the basis for your conclusion that there's been a change?

A Well, as you noted from the kinds of work I do, I have a kind of interesting vantage point on the situation, which is that I work in the public [3-135] sector in the private hospital sector, as well as in my own private practice. And in all three sources of personal experience, as such, I've seen a marked decrease in the use of long-term hospitalization. There's been increasing evidence that hospitalization should be avoided any time it's possible largely because of the enormous cost involved financially, and because of the enormous human cost in terms of family disruption that occur when a person has to be hospitalized. So that there's been a trend away from hospitalization if at all possible, and where necessary, absolutely necessary, there's been a tendency to make those hospitalizations as short as possible. So the thrust has been to shift wherever possible to focus the treatment to the out-patient sector.

Q Okay. Has there been any change in the focus of treatment or the mix of treatment as between public facilities and private facilities, in your experience?

A Yes, there has. There's been a trend toward trying to increase the number of providers in the private

sector, the number of professionals qualified [3-136] to provide those services. And as a result of that there has definitely been a shift toward the private sector and away from the public sector for out-patient services.

Q And that shift from public to private sector treatment, has that had an impact, for instance on the Mass. General Hospital clinic?

A Yes, in fact it has. It's enabled the Department of Psychiatry to develop a very comprehensive range of psychiatric and psychological services and to pay much more attention to many more of the subtle kinds of disorders that were previously misdiagnosed or undiagnosed, so that we are able to have developed a very first-rate range of services as a result of this.

Q Now, how long have you been with the Mass. General Hospital again?

A Since 1972 is when I joined the staff, although as Director of Psychology it's been since 1976.

Q And can you identify the beginning or the onset of the development of this trend that you identified, the change from public to private treatment for these kinds of conditions?

A Yes. It's very definitely been within the last [3-137] three years, three to three and a half years because it coincides with the advent of our new Chief of Psychiatry quite closely.

Q Now, you just mentioned, I think, a couple of moments ago a policy favoring the increasing—the development of increasing the number of providers for mental health services?

A That's correct.

Q Have you actually observed a change in the Commonwealth of Massachusetts with respect to the number of providers?

A In the Commonwealth itself—

MR. MC GOVERN: I think I will object. He has experience in three specific localities. We're now talking about numbers of providers. I don't think a basis has

been laid for him to know what's going on all over Massachusetts with respect to specific numbers.

THE COURT: He may answer that he doesn't know, but until I find an answer I won't be able to—you may answer.

A Yes, there has been an increase in the number of providers as evidenced by the increased numbers of psychologists who are being licensed for [3-138] independent practice by the Board of Registration of Psychology in the Commonwealth.

Q And you're specifically familiar with the licensing practice in the Commonwealth.

A Yes, I am.

Q Are you aware of the extent of the increases in the number of providers of psychological services in the Commonwealth?

A Very definitely from a number of sources.

Q And could you identify the sources?

A Two of the major ones that, perhaps, I can share. One is in our own private group practice; the striking increase in the number of requests for employment by providers of psychological services that come to us each week in the form of resumes. I'm also familiar with the rapid expansion of group practices and private clinics throughout previously unserved and underserved areas of the Commonwealth.

Q And could you identify the particular group practices and the areas in which they operate?

A Certainly. Earlier, you heard of one in the area, a previously essentially unserved area, which involved the Groton-Pepperell-Littleton-Townsend [3-139] area. And there's a similar one—there are several clinics, in fact, in Newburyport, Amesbury, Georgetown and the Rowley area, the Danvers-Peabody area. It was also been an influx of several group practices in the Burlington-Woburn area, in the Worcester-Marlboro area, just to mention a few.

Q Now, do you know whether any of those particular group practices operated in the Commonwealth prior to 1976?

A Yes, I do know that. The answer is no. Excuse me, I was looking over at my colleague—Dr. Hefele's date was 1974?

Q I believe he testified his group practice was in 1976. Now, in the course of your experience have you observed since 1976 any change in the distribution of mental health services among various segments of society or socio-economic classes in society?

A Yes, in fact, that's been one of the most striking changes in recent years.

Q And could you please identify from your personal experience the nature of that change?

A There's been a striking increase in the utilization of out-patient mental health services [3-140] by working class and lower middle class individuals in the Commonwealth.

[3-142] Q Now, on the basis of your professional experience have you become familiar with any impact that treatment for mental and nervous conditions has on an employment-related problem?

A Very definitely. In the profession, the mental health profession, it's accepted wisdom that symptoms such as, or signs such as decreased productivity, increased absenteeism, increased industrial accidents, increased grievance procedures, increased employee turnover and the [3-143] like can often be symptoms of mental illness in the employees where these problems are occurring. I've seen in my own private practice and I've seen it in the cases I've supervised at the hospital as well, in the mental health center, is that psychological interventions with such individuals have an impact not only on changing these problems in the job area but also have an impact in terms of the families of these individuals, who are very often very troubled people. Actually, there's one other point as well, which is that we've also observed—and I've observed in these settings—individuals

who previously were kept in state hospitals and considered essentially incurable, with appropriate out-patient treatment and support services have been able to become independent citizens who've been able to hold jobs and contribute meaningfully to the Commonwealth.

[4-3]

[TESTIMONY OF THOMAS G. McGUIRE]

DIRECT EXAMINATION
BY MR. MONTGOMERY:

Q State your name, please.

A Thomas G. McGuire.

Q Where do you live?

A 86 Greenlawn Avenue, Newton Center, Massachusetts.

Q And where are you presently employed?

A Presently I'm a post-doctoral fellow in mental health evaluation at Yale University. This is a temporary position. I'm also on leave from the Department of Economics at Boston University.

Q And what is your position at the Department of
[4-4] Economics at Boston University?

A I'm an assistant professor of economics.

* * * *

[4-7] Q Are you familiar, Dr. McGuire, with the subject of mandated state benefits for the treatment of mental and nervous conditions?

A Yes.

Q And has any of your work—does any of your work
[4-8] bear directly on the subject of mandated state benefits for the treatment of mental conditions?

A Yes. I highlight two things. The work that I'm beginning this year, which I haven't done, from which I can't draw any conclusions, is on the effect of various state regulations, including direct recognition laws, including minimum mental health benefits, including licensing laws on the delivery of mental health services. Work that I have completed is in a book that I have written that is going to be published this fall by Ballinger Press,

called "National Health Insurance and Psychotherapy: Issues and Evidence," and that book is a study of the federal counterpart of that state regulation, and that federal counterpart is compulsory insurance from the federal level of national health insurance. But I would say that many of the same principles apply at the federal and state level.

Q Now, in analyzing the subject of mandated benefits for the treatment of mental and nervous conditions, could describe the general approach that you take?

A Well, what needs to be done in the beginning is to consider what the issues are, and in doing that [4-9] it's necessary to take a look at what the practices are in the different states and what the policy proposals are both at the state and the national level. To go from there to the study of the actual workings of the various sectors that are involved, and by that I mean the insurance industry which provides coverage for these services and the delivery systems themselves—what are these insurance services covering? Having come to some understanding of them, then I applied economic analysis to try and understand where these things work well, where these things do not work well, and use that to identify any questions that have not been adequately addressed by the existing literature, which would be both theoretical and empirical. Then I proceeded from there to do some of my own research and to try and fill what I thought were the important gaps, putting my research together with what is already in the literature and then to try to draw some conclusions from policy.

Q Specifically, have you studied the functioning of the market for mental health services and in addition to that the nature in which the insurance [4-10] mechanism in the United States has delivered those services—reimbursement for those services?

A Yes.

Q And could you describe a little bit more specifically the process that you follow in analyzing the market for delivery of those services?

A Well, I would say that the process goes under a code name in economics of market failure, and what that means is that if you are looking at a market, either the market for insurance for these services or the market for psychotherapy, you use economic theory to try and shed light on what might be the problems in this kind of market. Then, with this as a guide, with economic theory as a guide, try to find out something about the seriousness of those problems through empirical research.

Q And as a result of the analysis that you have made of insurance markets and the market for psychotherapy have you been able to draw any conclusions as to the nature of the, as I think you call, economic deficiencies in the market?

A Yes.

Q And could you please identify the deficiencies [4-11] that you are referring to?

A Well, the major deficiency I found in the market for insurance for mental health services has to to with adverse selection. In the market for the delivery of services itself, the major deficiency is that many of the benefits of receiving mental health services appear not to go directly to the user of the services but go to society, which private markets then may not respond correctly to that problem. And a third deficiency, I'm not sure quite where to put it, but it has to do with the fact that voluntary markets are not very good in incorporating society's wider interests, compassionate interests, in the treatment of individuals.

Q Okay, now, starting first with the concept of adverse selection and its impact on the market, could you please define what you mean by that term, adverse selection?

A Okay. Adverse selection results from the way insurance companies must price their services, which is insurance coverage to individuals and groups. It's a fact of life in the insurance industry that premiums must be set according to [4-12] the average behavior of groups, for example, the residents of New York State, the em-

ployees of a certain firm, even within the employees of a certain firm it might be the employees twenty to thirty years old, but, nevertheless, a group must be identified and the premiums set according to the expected average behavior of that group. Now, within the group that the insurance company uses to set its rates, only a very few people will be exactly average; none might be exactly average in fact. Many people will be on the one side of the average and the others will be on the other. Some people actually present more risk to the insurance company than the average; some will present less. Now, if insurance is provided in a voluntary manner by a market in which people may or may not choose to buy the insurance, then once a premium is set true for a group, the people who present more risk to the insurance company, in fact, than the average will find the insurance an especially good deal. For them the premium is too low in some sense. It does not accurately reflect the risk the insurance company must bear when it takes their policy. But the [4-13] people on the other side of the average, the premium will be too high in that the risk they really present the insurance company is much lower than that referring to the average premium. So if people can choose or not to take that insurance, the people who are worse on the average risks will be the people who choose it, and the people who are less than average in terms of risk may not choose it. And that's where adverse selection gets its name. The insurance company, because it has to rely on the voluntary decision of people to take or not take their policy, draws an adverse selection of the population they try to insure.

Q Now, in an insurance market, or in a market involving an insurance benefit, which may be subject to serious adverse selection, how do consumers in the market express their preferences or their choices with respect to whether they want a particular benefit?

A Well, it's really very simple. They choose a policy or not choose a policy. If there is more than one option available on the market, they would choose the one which,

according to their [4-14] one perception of their risk and judging that in relation to the premium cost they would choose to buy it or choose not to buy it.

Q Have you been able to identify any implications with this very general notion of adverse selection as for policy concerning mandated benefits for treatment of mental conditions?

A Yes.

THE COURT: Could you repeat the first part of that question? I didn't follow you.

MR. MONTGOMERY: I will try to repeat the question.

I think the question was, have you been able, in the course of your experience, to identify any implications which this concept of adverse selection, theory of adverse selection has for government policy towards mandated benefits for treatment of mental and nervous conditions?

A Yes. I think in order to answer that, if I may, it would be helpful for me to first describe the implications of this for the workings of the insurance market and then describe how policy [4-15] should react to the market.

So, what are the implications of adverse selection for the workings of insurance markets?

Well, I have described how rates need to be set by insurance companies and how individuals may respond to those rates. Well, you can imagine the insurance company coming into a group or a firm, setting rates appropriate for the average person in that firm. They don't get the average person. Some of the good risks don't choose to buy the policy. They get a preponderance of the bad risks in the firm. This means that the original rates the insurance company set, appropriate for the average, are not appropriate for the people who chose to buy the policy, and these are the ones they actually have to cover. Now, the insurance company will react to this in some way. A sensible thing for them to do will be to raise the rates—try to raise the rates in order to be high

enough to cover the people who actually choose their policy. Now, one effect of this is immediately to change the perception of the individuals who buy it about the benefit from their point of view of buying the policy. The [4-16] people for whom it was a real good deal in the first place, those who are the worst risks in the firm may still find it a good deal, but now you have raised the premium, and some of those people who were the better risks, who still found it worthwhile to choose, now may find that it's not quite so worthwhile for them. So, by raising the premium the insurance company actually serves to draw a worse selection from among the insurance pool. So, the reaction of any insurer to the problem of adverse selection of raising the rates may or may not fix the problem. It may, but on the other hand, when you raise rates you tend to draw even a worse selection from the pools. So, even thinking of just a single insurer dealing with the group of potential enrollees, the problem of adverse selection may lead to this viscious [*sic*] cycle in a way of bad risk pool, trying to raise rates to compensate it, the risk pool deteriorating, raising rates again, further deterioration of the pool until, in the extreme, it could be that there is no premium the insurer could set that would cover the costs of the people who actually buy the coverage. Now, that's the problem just from [4-17] the perspective of a single firm. Actually, in a market there will be competition among firms for coverage for individuals. And this can reinforce the tendency of adverse selection to destroy the marketability of insurance. What I mean by that is that even if a single insurer is offering a benefit that is chosen by some employees, some competitive insurance company may also have had a shot at insuring some of these people. And a competitive strategy in the context of adverse selection would be to try and draw away the good risks from the existing insurance company and leave them with the bad risks. And the way to do that is to set slightly lower benefits at less cost. That has the

effect of being more attractive to the better risks—the worse risks stay in the original pool, the better risks leave for the new policy; and this sort of competition of retracting benefits to try and keep only the good risks, in a competitive setting can lead to a retraction, retraction, retraction, until neither insurance company finds it can compete by offering any extensive benefits at all.

[4-18] Q Okay. Now my original question would be the implications of this concept of adverse selection and its effects on policy towards government mandated benefits for treatment of mental health?

A Well, this is a golden opportunity for public policy. Adverse selection can have the effect of destroying the marketability of insurance even in the case where, if the insurance companies could price the policies correctly, everybody would want to buy them. It's wrong to conclude in the context of adverse selection that if people aren't buying the policies that are offered it somehow is an expression of consumer preferences. It is an expression of consumers' desires but only in response to prices that are really inappropriate for them. These prices that insurance companies set are average prices for groups, not the true prices that would be appropriate for each individual in the group. So, when you see someone declining to buy something at a price that is way too high for them, that's not to say that they wouldn't want to buy it at they price that were appropriate to them.

That's what adverse selection can do. Now, [4-19] in this kind of context the government can step in, set a mandated minimum level of coverage which prevents insurance companies from engaging in the kind of ruinous competition for the good risks, leaving the bad risks with their competitors. That has the outcome of spreading the bad risks and the good risks around so that each insurance company can survive. It will be prevented from trying to attract just the good risks and maintain a level of coverage. And this fact changes your perspective on the nature of government intervention. Far from

being a kind of intervention that subverts consumer preferences, it's a kind of intervention that facilitates consumer preferences in a sense that the government mandate can mimic the result of a market if it were able to work correctly by setting prices appropriate for individuals. The market as it exists of adverse selection is not a well functioning market. People are being offered to buy something at prices that aren't appropriate. By mandating coverage, you can imitate the result that would have occurred had the market been able to set those prices correctly.

[4-20] Q Thank you. Now, how does adverse selection specifically relate to the subject of mental health and mandated minimum benefits?

A Let me answer that by describing exactly the circumstances in which adverse selection occurs and showing that they apply to mental health.

The ingredients for adverse selection are two. One is that the insurance company sets rates by the average in a group, and that's almost always true. The second ingredient is that the people in the group are not the average at all. Some are much worse than average, and some are less than average, and they know it. That they see that these rates which may apply to the average don't really apply to me. In the case of mental health, I may think it's very unlikely that I will ever need mental health benefits. I may be that sort of person, which is not to say that there is not some chance but if I am right about that likelihood then the appropriate premium for me, who might be a very good risk, would be quite low. And there's other people in that group who know that it's very likely that I will need to seek mental health services. [4-21] And for those people they will say, this premium is a great deal, and it may be true if their likelihood is correct that the appropriate premium for them would be quite high to cover their risk. Now, there is no doubt that this kind of thing can lead to adverse selection. Now, I think if you look at the kind of services

that are mandated by states—that state mandate insurance companies cover, it's not an accident that they include the things that they do, but the things that they include are services that are very likely to be subject to adverse selection.

Q Can you think of any other examples other than mental health that are prominent subjects of mandated intervention.

A Well, the most commonly mandated service has to do with coverage for newborns. According to Dr. Larson's paper, thirty-nine of the states mandated coverage for newborns. Now, I think that you wouldn't expect an insurance company to have anything against coverage for newborns, any more than they have anything against coverage for the mentally ill. But it is the kind of [4-22] coverage which sets up insurance companies to get slaughtered by adverse selection. Imagine yourself as being an insurance coming in to cover a firm which has young men and young women in it, and you're considering what would happen if we cover newborns. Well, you think we have to be very careful now to discriminate among, if we can, employees in the firm. And suppose we are even able to be so discriminate as to set rates that vary by the marital status of the person and by the age. Even if you are able to do this—I'm not sure you are always able to do it—you might try to set rates appropriate for young married women aged—the childbearing age—say, twenty-five to forty. But even if you do that, I think insurance companies instinctively know that setting rates appropriate for that group on average is still going to lead to adverse selection in that the people in that group, the young people, young men and women, have a good idea about whether in the course of a year or in the course of a few years, they are likely to need the benefit of coverage for newborns. And for those of the [4-23] employees who know that it is very unlikely we are going to have kids—either we don't want kids or we've had all the kids we are going to have—that kind

of coverage is useless for them. On the other hand, there will be people that the insurance company cannot identify and price separately who know that it's very likely that within the next few years I'm going to be having a baby, and the coverage for newborn care will be something that is very valuable to me. So that people will know and be prepared to make choices based upon their knowledge of their own likelihood about whether or not they want this coverage. So the insurance company can expect to get a terrible adverse selection of risk if they try to offer this kind of coverage. And all a competitor has to do is come in and offer what is an otherwise similar policy with no coverage for newborn care and the competitor is going to get all the people who are not going to have babies and the people who are going to have babies are going to go to the original company, and the results are quite predictable that they will have to bear a heavy burden in financing [4-24] the services. So, no one company can venture into this coverage without getting killed by its competitors. The only way to have it is to have this kind of competition prevented. And I would say mental health is the same case, that a company venturing unilaterally in the coverage for mental health services is likely to get the people who think and probably know that they are more likely to use it.

Q Now, from your experience have you come across any evidence that this general concept of adverse selection, as you have been discussing for a while, plays a role in the insurance market for delivery of mental health services?

A Yes.

Q Could you, please, identify the information that you examined?

A First of all, it's not a thing that—adverse selection, that is—is not something that's easy to see in the sense that if it's really powerful, if adverse selection is really working powerfully, the market is just not there. So, it's in a sense one piece of evidence for adverse [4-25]

selection is the absence of coverage for a benefit which you might otherwise think people would want. But there are circumstances under which you can observe adverse selection at work. And this is in cases where you see people making choices among insurance options and they seem to be making them on the basis of coverage for, for example, mental health services. And the place where I think it is most evident is for federal employees, who are about five million adults who have probably the best menu of choice of insurance plans of anybody in the U.S. There are two nationwide plans which federal employees may choose. One is Blue Cross-Blue Shield; one is Aetna. And within any region federal employees can choose among local insurance plans or pre-paid group practices or other things.

In 1974, Aetna, which is a commercial insurance company, undertook to review its claims experience with respect to mental health benefits. They did this because they saw their claims seemed to be high and seemed to be higher than the other carriers that were available to federal employees. They saw that their mental [4-26] health benefits were higher than they were and concluded that the reason they were higher was because of anti-selection, as they called it, but adverse selection is the same thing. They concluded that because they found that a disproportionate number of their benefits were used by people who were new to the Aetna plan. They interpreted this as meaning that people foresaw that they were likely to use mental health benefits and then selected into the Aetna plan. The Aetna coverage at this time was perceived to be slightly better than Blue Cross-Blue Shield, even though they look similar, in that they were both $100 deductible, both twenty percent co-insurance rate up a very large limit. But the—

Q Do you know what that limit was, by the way?

A I think it was $250,000. It was essentially no limit on psychotherapy.

Aetna was perceived to be better because of the amount they would pay to therapists. Blue Cross-Blue Shield paid on a usual customary fee. I think Aetna paid actually the price that the—whatever price the psychiatrist charged. So their coverage may have been slightly more [4-27] generous.

Now the response of Aetna to this review was to—they thought this problem was serious enough so that they responded in a classic way when adverse selection is present by retracting their benefits in the case of mental health services to a limit of twenty visits per year, whereas before there had been no limit at all. Now, their expenses for mental health services in 1975 went down after this retraction of benefits, but the significant thing for adverse selection is that for the first time in about four years Blue Cross-Blue Shield went up, and I think it's obvious that the effect was the people in Aetna who had been using a lot of mental health services now were no longer in a plan that covered their problem most generously so they switched from Aetna to Blue Cross-Blue Shield. And even in with the Blue Cross-Blue Shield plans, it is possible to see some indication of adverse selection. Blue Cross-Blue Shield offers two options nationwide for federal employees. One is the so-called high option, which has the deductible of a hundred co-insurance of twenty percent, limit of [4-28] $250,000. The other is the low option, which differs only in, as far as I know, a slightly higher deductible of $250 instead of $100, a slightly higher co-payment of twenty-five instead of twenty percent. I think the limit may be somewhat less also, but still nothing to constrain psychotherapy. And if you look at the utilization among people in the high option and low option whose coverage really doesn't differ that much, co-payment of twenty versus twenty-five percent is not that significant a difference. But the utilization of mental health services is vastly different in the plans. And that suggests that federal employees are alert to coverage for mental illness, have a good idea of

whether or not they are likely to use the services, and are prepared to choose the plan on the basis of the one that gives the best coverage for them. And that's evidence of adverse selection.

Q Okay, now to take us back to square one for a second. You originally identified I think three factors which you, I think, described as deficiencies, or problems which inhibit the delivery of mental health services by the insurance mechanism.

[4-29] The first was adverse selection. The second I think you said was the fact that the benefits which accrue from treatment for mental and nervous conditions extend beyond the individual who seeks the services. Could you explain what you mean by that second factor?

A Yes. The first adverse selection referred to the insurance market itself. The second one, the fact that the benefits of receiving mental health services go beyond the individual who receives them, has nothing to do with insurance per se, but about the market for services. And it is simply that when someone uses mental health services the benefits of them doing that appear not to fall just upon the individual user who may feel better because of it but upon society as well.

If I could just quickly give an example of another case of this—pollution is an example of, instead of a benefit, a cost that society bears of some individual or corporate action. If a steel maker is making cars and they dump some effluent in Lake Erie, then one of the—some of the effects of their activity fall upon [4-30] wider population groups, and society responds to this either by prohibiting activity outright or by taxing it to—as an expression of society's interest in the activity.

Q Now, with respect to mandated minimum mental health benefits, what specific additional social interests, I guess as you call them, are certain?

A Well, I would identify two. One is an interest the society and the people in society have in the well being of other people—of people who may be mentally ill. And

that's just some compassion involved in that one. That's not one that I consider myself having special expertise with respect to. The other one which I would identify is that apart from a personal interest in someone else's welfare, the way mental illness is manifest in our society and the way we pay for those manifestations is something that builds in a collective interest in each individual's mental problems. Now what I mean by that is that if you think by not covering insurance—not covering payment for services directly related to mental illness —that somehow we avoid the collective burden of mental illness, now, I think that is basically [4-31] incorrect.

Q Why is that?

A In 1975, eight hundred thousand people were treated in public mental hospitals for mental illness. Nine hundred thousand people were treated in general hospitals as diagnosed as being mentally ill. Thirteen million people were treated by the general medical sector, by private physicians who are not psychiatrists, where primary diagnosis was mental illness. Two hundred thousand people were kept in nursing homes where they were diagnosed to be mentally ill. Three hundred and fifty thousand people were in VA hospitals treated for mental illness. Community mental health centers treated some couple million, 1.5 million people. Now these services are not paid by the individuals who use those services. Taxes support public mental hospitals. Taxes support community health centers. Medicaid pays for care in nursing homes. General insurance, commercial and Blue Cross-Blue Shield pays for care in the general medical center by private physicians and in hospitals. So these are—this set-up builds in an inter-dependence [4-32] among people in the problem of mental illness.

Now, if I can just add to that a bit—

Q We will have to stop you, just to ask you to back track for a second. You mentioned that there were thirteen million people who were with mental and nervous conditions treated by physicians, and I ask you to identify

what implications that particular mode of treatment has for government policy with respect to mandated benefits for treatment of those conditions?

A I think I can do that. I think it's a more general answer, but an implication is that according to the President's Commission on Mental Health, which was completed in 1978, general physicians, that is, general practitioners, internists, others, are not adequately trained to deal with problems of mental illness; so what you have is people who have problems going to seek help from the general medical sector, private physicians trying to help them in the ways that they have been trained to help, which are basically giving them drugs and doing surgery on them. And it is not clear that this is the appropriate way [4-33] to deal with mental problems. It may be more appropriate to deal with them more directly as psychological problems by specialists in mental health rather than by people trained in physical health problems. That's true with respect to private physicians, and it's also true when mental health problems are manifest and dealt with outside of the mental health sector.

Q Doctor, has there been any empirical research that has tried to quantify or confirm whether increasing the availability of mental health services has some off-set or reducing effect on other medical expenses?

A Yes.

Q Would you, please, explain the history of some of that research?

* * * *

[4-36] Q Dr. McGuire, I think we left off with the question has there been any empirical research to confirm the extent to which an expansion of the availability of mental health care would result in a reduction in expenditures for other medical care?

A Yes.

Q Are you familiar with that research?

A Yes.

Q Doctor, based upon your experiences as an economist in the health care field, further on your research in connection with your forthcoming book on psychotherapy, and further on your experience as a member of the review panel on the efficacy and cost effectiveness of pschytherapy for the United States Office of Technology Assessment, and further on your membership of the review committee—the Epidemiologic and Services Research Review Committee of the National Institute of Mental Health, do you have an opinion as to whether the expansion of the availability of [4-37] services for treatment of mental and nervous conditions reduces medical expenditures for physical care?

A Yes.

Q What is that opinion?

A I think there is a significant offset of medical expenditures when mental health services are provided.

Q Could you be more specific on the nature of the offset?

A Studies have revealed that—most of the studies report offsets—

MR. GREENFIELD: Objection.

THE COURT: No, I'm going to sustain it.

Q Doctor, do you have an opinion as to whether there are any dangers or pitfalls associated with the government mandating that insurance companies provide treatment benefits—benefits for treatment of mental conditions?

A Yes.

Q In your opinion, what would those dangers be?

A I think there's two major dangers. One is that, as a result of mandated insurance coverage, people [4-38] will use a lot more of the services, and it will cost a lot of money to provide them. The second danger is, in the case of mental health services, that the state mandate coverage for a service that is used by a small portion of the population, possibly by members only of the upper income groups, in which case the policy would effectively

redistribute purchasing power from the general taxpayer, general workers, to members of the upper income groups.

Q Okay, now. With respect to the first danger that you mentioned, increased demand and cost, could you elaborate on what you mean by that?

A Sure. I think it's important to keep in mind when you start discussing cost and its implications for policy to distinguish between costs that represent simply a shift in the way something is paid for and between that and an actual increase in the total amount of cost that society is bearing as a result of insurance legislation. The first thing is not worrisome at all; the second thing may be.

For example, if you take a look at the experience of Blue Cross-Blue Shield in Massachusetts before and after the mandated minimum mental health [4-39] legislation, they report that—

MR. GREENFIELD: Objection.

THE COURT: Sustained.

Q Doctor, are you familiar with the experience of Blue Cross-Blue Shield with respect to expenditures for treatment of mental and nervous conditions, both before and after state legislation mandated such benefits?

A Yes.

Q What was that experience?

MR. GREENFIELD: Objection.

THE COURT: I'll allow it.

A Before 1976, expenses covered for mental conditions were approximately $5- or $700,000 per quarter. After 1976, in 1978, specifically, expenses were about $7 million per quarter.

THE COURT: Could I have that first figure again? I'm sorry.

THE WITNESS: $500,000.

THE COURT: $500,000? Thank you very much.

THE WITNESS: That's approximate.

Q Now, what are the implications of those before and after figures for the increased cost danger [4-40] to this legislation that you've mentioned?

A You don't know, just by looking at the figures, whether or not they represent simply a shift in who's doing the final payment for the services or whether they represent an increase in the amount of mental health services being provided. If all that's being said is that before 1976 we didn't offer this benefit and, therefore, it didn't cost us very much and after 1976, yes, we did offer this benefit and lo and behold, it does cost us something, then that's not saying that society in any sense is paying more for mental health services. It's just that the people aren't paying for it directly any longer, but they're paying premiums to the insurance company who then pays it to the providers. That may be experienced as an increase in the cost to the insurance company itself, but its's not an increase in cost to society. It's simply a transfer.

Q Well, is there any way to assess the extent to which increased insurance expenditures represents added costs or a shift in costs?

A Yes.

Q How could that be done?

[4-41] A Well, you can't do it, first of all, you can't do it by looking at simply by looking at the claims experience of Blue Cross. To do it you need to be able to compare what people did before they had insurance coverage to see how much they spent on mental health care and compare that to what they did afterward. By just seeing the total claims that Blue Cross paid, you only see the second thing; that is, how much they use after they have insurance. You lack the baseline by which to make a comparison. But there has been research in mental health that has investigated that, some of which I've done myself and the rest of which I reviewed for the National Institute of Mental Health in my paper, "Financing and Demand For Mental Health Services."

Q And from that work, have you drawn any conclusion, with respect to the added costs and shifting costs dichotomy?

A Yes.

Q What was that conclusion?

A With respect to the added costs? I should say, first of all, that the research in the area of the effect of insurance on utilization of mental [4-42] health services is not nearly so well developed as it is in the case of insurance on general medical services, in which research has been going on for a longer time, in which there's been more of a settling of exactly what's happened. So it's impossible to make a large number of detailed conclusions, but there are some things you can say with confidence, and those, I think, are important for consideration of mandated mental health benefits.

Q And what are those?

A The first thing would be an obvious one, I think, to an economist but is worth saying anyway, and that is, demand is not unlimited; meaning that, no matter how much insurance you give people, they're not going to go out and spend all their time receiving therapy. There was some concern evident in the policy literature that if you give people insurance for something, they'll go wild and spend half their income on receiving psychotherapy or other mental health services. But that's not the case. However, it is the case that the responsiveness to insurance of demand for mental health services is greater than it is [4-43] for general medical services. And to be specific about that, take the case of the demand for outpatient services, say the services of a physician in private practice, as compared to a psychotherapist in private practice. Generally, research in health services finds that if you increase the amount of insurance coverage a person has by about 1 percent, meaning that if, instead of having co-payment of 50 percent, they now pay only 49 percent—if you imagine a little experiment of giving them a little bit more insurance, the response is to that 1 percent increase in insurance to increase the utilization of services by about .5 percent. So that they do increase. When people have insurance they do tend to buy more of the physician services, but they don't increase it very

much, only about half as much as the increase in the insurance coverage itself. If that's compared to the demand for mental health care on an out-patient basis, it's less. That is, the demand for mental health services is more responsive to insurance than is demand for general medical services. The findings from my research is that if you increase insurance [4-44] to someone by 1 percent, on the average the increase in demand is 1 percent more greater, or slightly greater. So, it's considerably more responsive than the demand for general medical services.

Q Okay. You've identified the potential for an increase in demand as a result of an increase in insurance coverage. What are the implications of that phenomenon for government policy, with respect to mandating minimum mental health?

A Well, it means you have to be careful, that it is possible that if you go too far and include a great deal of mandated insurance coverage, then people will respond to that large increase in insurance with a significant increase in demand. Now, I want to interject at this point that some increases in demand appear to be appropriate, based on my testimony so far. But, it's important to recognize that you can go too far and include too much insurance coverage and get into increases in demand which may not be warranted. But, in order to be prudent, I think it is prudent to set a relatively strict limit on mandated benefits, such as $500.

[4-45] Q As in Massachusetts?

A As in the case of Massachusetts.

Q Are there other control mechanisms that can be utilized, either by the statute or by insurance companies, to control utilization and demand?

A. Yes.

Q Will you give us some examples?

A Well, putting a limit on the total liability of insurance companies is one way to limit demand. Other ways are by deductibles, which are payments to be made by the insuree before the insurance company benefits can

begin. Co-payments, which means that the insured pays some portion of the cost along with the insurance company. Claims review on the part of insurance companies to investigate which claims appear to be legitimate and worth paying. Peer review mechanisms are possible—a whole series of things can be done.

Q Okay. You mentioned co-payments. By that, you mean that for each visit a client or a consumer has to pay a certain percentage of the fee?

A Either a percentage or a fixed amount.

Q Or a fixed amount. Do you know whether Blue Cross-Blue Shield in the experience that you [4-46] mentioned you're familiar with imposed a co-payment requirement on their clients?

A I believe they don't.

Q Are there any specific evidence that you have utilized in the course of your research concerning the actual cost of mandated benefits for the treatment of mental health?

A Yes.

Q What are the costs, or how would you—

MR. GREENFIELD: Objection.

THE COURT: Sustained, as to form.

Q Now, you've also mentioned that a second danger besides increased cost and demand, and that was, I think you were referring to what I would describe as a distributional effect?

A Yes.

Q Could you elaborate a little bit more on what you mean by that?

A Okay. The idea is that you're providing a benefit to society and you're requiring a certain portion of society to pay for that benefit. The concern is that the people who use mental health services might come from a portion of society—the fear being, specifically, that they are people only [4-47] with a lot of education and a lot of money that will be the people who benefit from this

care, and the people who pay for it are sort of the average worker.

Q Now, in the course of your experience have you had occasion to study or consider the likelihod that that effect will occur or has occurred?

A Yes.

Q And have you reached an opinion?

A Yes.

Q And what's that opinion?

A My opinion is it won't occur in the case of the Massachusetts statute.

Q And why is that?

A First of all, my work on the effect of insurance coverage on demand for out-patient psychotherapy focused on the question of the distributional impacts of this because it is a serious problem in this policy and with respect to many other areas of mental health. And I investigated the extent to which different income groups respond to insurance coverage. I broke down the responsiveness by what the people in the top quarter of the income group do, what the third quarter and [4-48] the second and the first quarter. And my finding was that for the people who have the greatest amount of income, the responsiveness is very low to insurance coverage. It doesn't seem to make much difference at all to them how much is paid for insurance. But if you look at the responsiveness as it changes as you go down the income groups, the responsiveness increases, so that the responsiveness by the people at the bottom is much greater than the people at the top. The consequence of this is, after you provide insurance coverage the distribution of services is going to tilt, tilt away from the people whose demand is about the same towards the people whose demand has increased, and those people will be the people on the bottom rather than the top of the income group.

Secondly, I think the $500 limit is an effective way of stopping a lot of utilization by the people at the top who may be inclined to go into psychoanalysis, or

other insight-oriented therapy, that might not be used by the people near the bottom of the income scale.

And thirdly, the statute covers settings [4-49] in which the people who don't have a lot of income, that those are the settings that these people use. Community mental health centers, for example, are used by—or, more than half of the people seen in community mental health centers fall below the official poverty line. So, these are settings which, I think, either make an effort or people respond to them from both the lower, primarily the lower income groups in society.

Q Thank you. Doctor, have you had an opportunity to review a report entitled, Mandated Health Insurance Coverage and Study of the Review Mechanisms by Dr. John Larson?

A Yes.

MR. MONTGOMERY: If there's no objection, I'll provide a copy to the witness of the report.

Q Referring to page, beginning on page 67 of that report, which is marked as Exhibit 18 in this record, the section entitled, Conclusions—I guess really continuing on page 68 and 69—Professor Larson draws two conclusions. Would you care to comment on the first conclusion that he made?

A My comments on the second one would be quicker. [4-50] Q Okay.

A The second one, that each must receive an exhaustive examination as each proposal for mandated mental health benefits, I think, is a sensible one, and I would hope that any legislature would adhere to it.

Q Okay. And with respect to the first conclusion?

A The first one—I don't know if everyone has a copy—which is to place a moratorium on this kind of policy and then, if done, only to do it as an option, I am not convinced by.

Q And why is that?

A Well, first of all, if you consider the pluses and the minuses of this kind of policy, I think Dr. Larson

didn't give enough weight to the possible pluses. As I've testified already, I think adverse selection is a very important argument in considering mandated minimum benefits for mental health or for others, and although he mentions it at some point in this document, it's not given the weight that I would in considering the possible positive effects.

And secondly, there's no discussion that I can recall here about the possible offset [4-51] effects of a mandated service. And while this report was oriented toward the more general problem, I think of you're going to make a general recommendation, you'd be obliged to cover all the possibilities.

Q Thank you. I'd like to show you—

A Excuse me. I would have some more to say, though. That's on his neglect of what I consider the positive arguments. He also mentions the possible drawbacks of mandated mental health benefits, and this is my list. He uses the same dangers that I do. One, it's going to cost a lot. And, two, that it might be distributionally harmful. Although I think that these are the right issues, to assess the importance of an objection, he needs to martial some evidence to say how important it is. And my opinion about his evidence is that it is weak, very weak.

Q Thank you. Do you have any further comments on the two conclusions in the report?

A No.

Q Now, I'd like to show you what has been marked as Exhibits 22 and 23 in this case. And I'll ask if you've had an opportunity to review those [4-52] exhibits.

A Yes.

Q And do you understand the methodology that Professor Larson used—

A I think so.

Q —creating those exhibits. And Exhibit 22 is his calculation of nationwide additional premium cost for mandated benefits legislation.

A Yes.

Q Based on the Colorado experience; is that correct?

A Yes.

Q And Exhibit 23 is a similar projection, based upon the Maryland experience; is that correct?

A Yes.

Q Now, are you familiar with the accepted methods of projecting the economic consequences from an individual set of data from one market?

A Yes.

Q And do you have an opinion concerning the correctness of Dr. Larson's methodology?

A Yes.

Q And what is that opinion?

A I don't think it's very enlightening.

Q And could you elaborate on why it's not enlightening [4-53] in your view?

A Well, as I understand the methodology, it is taking the behavior in a small setting. By what I mean by that is, Item A on Exhibit 22, which represents a rate of utilization—$91 per person per year means that they are going to be using, anticipated using $91 worth of services per year. It takes this rate of service utilization and multiplies it by the number of people to whom it's supposed to apply, and this is now a national figure of the number of people. And then, by multiplying A times B, you get a national rate of utilization. Well, it seems to me that what this is is simply basing a projection on what will happen in a market solely on demand side of that market. That—one of the very important lessons in economics is that market outcomes are determined not just by demand behavior but by demand and supply behavior together. So, in a market you need to take into account not only demand considerations but also supply considerations.

THE COURT: Excuse me one moment, please. Okay. Go ahead.

Q Now, specifically with respect to the supply side [4-54] of the market for treatment of mental and

nervous conditions, have you had an opportunity to study the supply of mental health treatment providers?

A Yes.

Q And specifically, what's been involved in the study that you've done?

A Well, partly, I studied it in the course of my book. One of the papers that I've written, Market for Psychotherapy, has a section on the numbers of providers of different types and the projections of those numbers for years ahead and the consequences of some of those projections for different kinds of policies. But it involved seeing how many people are out there and how it's likely to change in the next couple of years.

Q And, Doctor, have you been able to calculated from the use of Exhibit 22 and from Dr. Larson's figures, I believe, on page 35 of Exhibit 18—36—the portion of his $5 billion projection represented by mandated mental health benefits?

A Yes. And this is somewhat approximate, but what I did was to take the portion of the $91 that is represented by coverage for nervous and mental conditions on page 36 of his report, which works [4-55] out to be roughly one-fifth. Nineteen is the portion that has to do with what our concern is here, and that is roughly one-fifth of the $91. So, it's simply by multiplication that one-fifth would also apply to the total.

Q There's roughly a billion dollars is what's involved?

A Roughly a billion dollars is what's involved.

Q Now, from your experience and from your study of the supply of providers of mental health treatment do you have an opinion as to whether there are in the United States a sufficient number of providers to meet, today, the $1 billion demand, if there were mandated mental health benefits in each of the fifty states?

A No, I don't think there is.

Q Do you have an opinion as to the extent to which the supply of providers would have to increase in order

to meet an assumed demand consistent with the $1 billion insurance expenditure?

A Some back of the envelope-type calculations suggest that we'd have to have roughly four times as many psychiatrists and others in business to be able to meet these projections.

* * * *

CROSS-EXAMINATION
BY MR. GREENFIELD:

[4-68] Q Is there any reason to believe that the mental health needs of persons covered by uninsured plans are any different than the mental health needs of persons covered by insured plans?

A I wouldn't think so.

Q You wouldn't think so?

A It's hard for me to assess needs, as I said, I couldn't.

Q As an economist have you ever heard the term, "There's no such thing as a free lunch"?

A Yes.

Q I'm sure you have.

A That's one I know.

Q Could you explain what that means?

A It means that if you're going to get something that has any scarcity value in society at all, then it's going to be paid for, even if not necessarily in cash—and that's the point of the whole statement—even if you don't think you're paying for the pretzels you go to a bar to get, it appears like it's a free—actually, [4-69] the expression came from a free lunch at a bar—that there's no such thing as a free lunch, even though it may appear to you; you pay for that free lunch either through higher prices of a beer or some other way.

Q Yes. And there's no such thing as a free benefit, a free health benefit?

A Well, if you could ask that in a way that—

Q You can't answer it the way I've asked it?

A Well, I think I'll agree with you, but I'm just not comfortable with the way you've asked the question. If

the health benefit involves resources used that have no value elsewhere, then it could be provided without any other cost. So, I—if you could ask it again, maybe I could give you a satisfactory answer.

Q Since you can't answer that, let me try something else. Assume that here's an ERISA plan. You now have some idea of what that is?

A I'm coming to learn.

Q Yes. Assume that there is an ERISA plan with a finite amount of resources.

A Meaning what?

Q Meaning it has just so much in the pot. There's [4-70] so much funds available between the employers and the employees.

A Okay.

Q And assume that the employers and the employees have decided as to how they want to allocate those resources between various types of health benefits, okay?

A Okay.

Q Now, if they've got to spend more for mental health because of a mandated statute, that means they're going to spend less for something else.

A That's subtraction.

Q Yes.

A Okay.

Q The pie is just so big, and if you cut one piece bigger, there's going to be just that much pie left.

A Which, of course, depends on your assumption that the pie is fixed.

Q Yes. Isn't it your understanding—well, I guess, you don't have an understanding—strike that. And as the pie becomes smaller because of administrative costs going up, there'll still be less for other types of benefits, won't there?

[4-71] A If the pie shrinks, there's less for everything.

Q Now, you gave an opinion concerning the relationship between expenditures for mental health and, if I understood it, reduction in other health costs?

A Yes.

Q And when you began that opinion or when you were questioned about that, you were asked whether the opinion was based upon prior research in that field.

A I don't recall being asked that, but I guess we could find out soon enough if I was.

Q Well, can we concede that that was part of the question? Well, did you rely upon prior research in the field?

A By whom?

Q By anybody.

A Yes.

Q Would you characterize that research as weak?

A Some of it.

* * * *

CROSS-EXAMINATION
BY MR. McGOVERN:

[4-77] Q Doctor, assume for purposes of this case that a lot of other states were to pass a mandated benefit law similar to the Massachusetts mandated law.

A Yes.

Q Would you at least go along with this to the extent of projecting that this would result in a very substantial increase in the cost of mental health care across the country? I'm talking—you can talk in terms of shifting or addition; I don't care which it is.

A Well, I think you have to, and I will. That you have to talk in terms of how much of an additional coverage this means to people in different states, and then based on that, how much additional services are likely to be used.

Q Wouldn't you say that at least you're talking in [4-78] terms of millions of dollars? I mean, you won't go up to a billion, but you're talking millions of dollars in this?

A I would expect, yes.

THE COURT: Could I ask a question? Would that be in addition, a million, or would it be a shift?

THE WITNESS: I would think the additions would be in the millions of dollars.

THE COURT: Okay.

THE WITNESS: Wait a minute—yes, I'm comfortable with that.

Q And, in fact, it would be in the terms of millions of dollars, wouldn't it, very likely?

A These are getting to be numbers that I don't want to respond to so quickly. If you're going to say millions, I would go along; tens of millions, I would like to sit down and think about it.

Q But you wouldn't rule it out, sitting here right now, would you?

A No.

* * * *

REDIRECT EXAMINATION
BY MR. MONTGOMERY:

[4-83] Q Now, you commented on some of the conclusions drawn by Dr. Larson. As I recall, on direct examination you testified that the evidence in support of his recommendation that mandated benefits should be allowed only as an option, you said the evidence was weak. Would you elaborate on what you mean by "the evidence is weak?" Would you elaborate on that conclusion?

A Well, the two dangers of mandated minimum mental health benefits that Dr. Larson pointed out in his report, whereas I said the ones that I talked about as well, these were: That it would cost a lost, first of all, and that it would have unfortunate distributional consequences. Now, with respect to the cost, the only evidence I saw [4-84] that was cited in Dr. Larson's report are the estimates by Blue Cross and Blue Shield of what they would expect it to cost in Colorado and what they would expect it to cost in Maryland. And having no knowledge about how those estimates were formulated I consider them as having more the appearance of evidence than the substance of evidence since they are numbers—in that sense they are evidence—but, not knowing

how to judge those numbers, whether or not they were made sensibly or on what basis of experience, if any, they were derived, I consider that evidence weak. The other danger has to do with the distributional effects, and the only evidence marshalled in that case is one sentence which refers to the alleged known unfortunate distributional effects of Medicare and Medicaid. And my understanding of the distributional effects under those programs is that it has not at all been unfortunate but they have done what they were supposed to do, to make sure the poor have resources in order to pay for care which has been done, and similar with elderly people. I think no one that I know of is seriously suggesting that we reconsider Medicare [4-85] and Medicaid on the basis of distributional problems.

Q If the mandated benefits were required only as an option by various state legislatures that have considered the question, would that avoid the problems of adverse selection?

A Not at all. It must be compulsory to avoid adverse selection.

* * * *

[4-87] Q Now, you mentioned on cross-examination, health maintenance organizations, or HMO's. Can you identify an HMO that you're familiar with in the Boston area?

A Well, I'm a member of one, the Harvard Community Health Plan.

Q In general, what role do HMO's play in the marketplace for delivery of health services?

A Well, they provide an alternative form of protection against health expenses. By joining an HMO, a member pays enrollment fees which are much like a premium from the point of view of the member, [4-88] and in exchange for the fees, the individual receives services directly from the organization rather than through a third party which would then collect the mass premiums to pay off the providers. But from the individual's point of view, its an alternative to health insurance.

Q Do you know whether HMO's provide services for treatment of mental or nervous conditions?

A Yes, they do; they must.

Q And do you know why?

A The HMO Act of 1973 included mental health services among those that HMO's were mandated to offer in their benefit package.

* * * *

EXHIBIT 3

IUE-AFL-CIO-CLC

May 16, 1979

HEALTH INSURANCE

General Electric

1. Provide 100 percent payment of all medical expenses after an employee has $1,000 out-of-pocket family medical expenses in a year for one illness.
2. Eliminate the Major Medical maximum amount and cover all expenses including surgical centers, nursing homes, recovery facilities, and replacement of necessary or required prosthetic appliances.
3. Provide for mental and nervous disorders to be paid the same as any illness including alcohol and drug rehabilitation treatment and treatment by a licensed social worker.
4. Reduce the family deductible under Major Medical to $100 per year.
5. Provide complete company payment for insurance for employees and dependents and retirees and dependents and for medicare—Part B.
6. Provide insurance coverage for employees and/or their dependents in the event of death, disability, or lay-off equal to their years of service with a minimum of two years.
7. Provide full payment for up to two hearing aids during a three-year period if prescribed by a physician and unlimited repair of hearing aids.
8. Extend full medical coverage to all retirees and their dependents.
9. Provide for payment of the private room rate if it is the only accommodation available or ordered by a doctor.

10. Provide the usual and customary doctor's fees for operating schedule and maternity.
11. Provide payment for emergency treatment for accident or illness for doctor and facility whether provided by a hospital, clinic, or by a special group or individual doctor.
12. Provide full payment for consultation or confirming opinion.
13. Provide full coverage for in-hospital doctor's visits.
14. Provide full payment for diagnostic coverage wherever performed.
15. Cover child from birth for all benefits automatically.
16. Provide dependent coverage for parents who are dependent on an employee for support.
17. Provide for an annual open enrollment period for dependents not previously covered.
18. Provide a common insurance carrier for all health insurance benefits.
19. Provide full payment of administrative charges.
20. Make all benefit programs subject to the grievance procedure and arbitration.
21. In the event that uncontested medical claims for coverages under the plan are not reimbursed by the carrier within a period of four weeks, the company should make direct payment to the medical provider, and the collection of the claim will thereafter become the responsibility of the company.
22. Provide that a written statement by an employee's doctor as to an employee's health or ability to work shall be controlling in determining his or her entitlement to Medical Care, LTD Benefits, and Disability Pension.
23. Provide coverage in the event of strike, walkout, etc.
24. Remove reference to temporary employees from the plan and provide coverage.

EXHIBIT 5

EXHIBIT D

GENERAL ELECTRIC

INSURANCE PLAN

As amended July 1, 1979

ERB 799.1

Indicates July 1, 1979 Modifications
(Effective dates indicated in Text)

[SEAL]

METROPOLITAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in New York State

(Herein called the Insurance Company)

Group Insurance Certificate

The Insurance Company certifies that it has issued Group Policies Nos. 663-G and 17500-G insuring the Employees of

General Electric Company

(Herein called the Employer)

under which certain Employees are insured on their own account and on account of their eligible Dependents for benefits as described on the following pages of this Insurance Plan Certificate-Booklet for Plan ERB-799.1.

If you are an Employee, as defined in this Certificate-Booklet, you will become insured on your own account and on account of your eligible Dependents in accordance with the provisions set forth in this Certificate-Booklet under the caption "Eligibility and Effective Date."

The Plan described in this Certificate-Booklet is not applicable prior to July 1, 1979.

The Contributory Insurance described in this Certificate-Booklet, is applicable only if you (1) have requested, (2) are insured and (3) are making the required contribution for benefits under such insurance.

This Certificate-Booklet is valuable to you and should be kept in a safe place known to you and your beneficiary. If you lose your booklet, an additional copy may be obtained from your employer.

This Certificate-Booklet contains those provisions of the Group Policy which affect Employees who are insured.

It is not a contract of insurance. The insurance is subject to the provisions of the Group Policy which constitutes the contract under which the insurance is provided.

No agent has authority to accept or waive the required proof of claim, nor to extend the time within which such proof must be given.

There is certain further information relating to your insurance on the next page of this Certificate.

This Certificate-Booklet is non-assignable and the insurance and benefits are non-assignable prior to a loss. The insurance does not at any time provide paid-up insurance, or loan or cash values.

METROPOLITAN LIFE INSURANCE COMPANY

/s/ Richard R. Shinn
RICHARD R. SHINN
President and
Chief Executive Officer

This Certificate-Booklet Replaces All Previous Certificates and Booklets Issued to You by Metropolitan Life Insurance Company Relating to Any Coverages Summarized Herein.

HEALTH INSURANCE CONVERSION PRIVILEGE

In the event of cessation of your Comprehensive Medical Expense Insurance because of termination of your service with the Company for any reason, you may arrange to obtain from the Insurance Company, without furnishing evidence of insurability, an individual policy for yourself or, if at that time you had insurance for your dependents under the Insurance Plan, an individual policy for yourself and such dependents in accordance with the following conditions. The individual policy may provide, at your option, Hospital Expense Insurance, or Hospital Expense and Surgical Operation Insurance or Major Medical Expense Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company, subject to the requirements of any applicable laws and regulations relating to the issuance of such insurance. The individual policy may be obtained by making application to and paying the required premium to the Insurance Company within thirty-one days after cessation of your Comprehensive Medical Expense Insurance, and shall become effective upon cessation of such insurance under the Plan.

At the option of the Insurance Company, the individual policy need not provide benefits in excess of those under your Comprehensive Medical Expense Insurance. The individual policy may provide (a) for the exclusion of any condition excluded by your Comprehensive Medical Expense Insurance but not any other pre-existing condition, (b) for reduction of benefits thereunder during the first year to the extent that benefits will not exceed those that would have been provided had your Comprehensive Medical Expense Insurance not ceased; and (c) for reduction of benefits thereunder by any benefits payable under your Comprehensive Medical Expense Insurance after such insurance has ceased.

The Insurance Company will not be required to issue the converted policy covering any person if it is indicated

that, at the date of termination he has similar coverage, or is eligible on a group basis for similar coverage, which together with the converted policy would result in overinsurance or duplication of benefits. The converted policy may provide that the Insurance Company may request, on any premium due date of such policy, information, concerning the existence of similar coverage on any person covered thereunder, and if any such person fails to furnish details of such coverage when requested may take such coverage into account in determining benefits payable under the converted policy.

Your dependents may apply for individual policies if they do so within thirty-one days after their coverage is terminated because they cease to be a dependent as defined on page 12 hereof, unless such termination was at your request, subject to the above provisions.

The converted policy shall also be available to your divorced spouse or former spouse in the event of annulment of your marriage, upon the divorce or annulment of the marriage while your spouse is covered as a a Dependent.

NOTICES TO EMPLOYEE

If you cease active work for any reason, you should find out from your employer what arrangements, if any, can be made to continue your insurance benefits in force, so that you will be able to exercise any rights you may then have.

If an individual policy of Life Insurance has been issued to you in accordance with the Life Insurance Conversion Privilege described in the Plan, payment with respect to the Life Insurance under the Plan shall be made only if such individual policy is surrendered to the Insurance Company without claim thereunder. The designation by you of a beneficiary under an individual policy of Life Insurance issued in accordance with the Life In-

surance Conversion Privilege, other than the beneficiary of record under the Plan, shall effect a change of beneficiary under the Plan to the beneficiary of record under such individual policy, regardless of whether or not written notice of such change is filed with the Employer.

The Home Office of the Insurance Company is located at 1 Madison Avenue, New York, New York, 10010.

GENERAL ELECTRIC INSURANCE PLAN
With Comprehensive Medical Expense Benefits
As Amended July 1, 1979

The provisions of this Plan are applicable to employees in all States. For employees employed in the States of California, New Jersey, New York, Rhode Island, and Hawaii and the Commonwealth of Puerto Rico, the Weekly Sickness and Accident Insurance described in this Plan will be adjusted to take into account any similar benefits provided for them pursuant to the laws of such jurisdictions. Such employees will receive an appropriate supplement to this Plan describing the benefits provided pursuant to said laws and the applicable modifications in the benefits and contributions set forth in this Plan.

LIFE INSURANCE

(For Employees)

As a participating employee, the amount of your Life Insurance until you reach age 65 will be two times your normal straight-time annual earnings. This amount will vary with changes in such earnings. However, if, at the time of death prior to age 65, the amount of your Life Insurance is based on earnings which are lower than your highest normal straight-time annual earnings at any time during the five years preceding the date of death, then the highest normal straight-time annual earnings during such five year period will be used in determining the amount of your Life Insurance. For employees whose regular work schedule is 35 hours per week or more, the minimum amount of life insurance prior to attainment of age 65 will be $15,000 (effective January 1, 1980, $20,000).

If you continue in Company employment beyond the end of the month in which you reach age 65 and your death occurs before your continuity of service is terminated,

the amount of your Life Insurance will be based on your normal straight-time annual earnings reduced by an amount equal to 1.1% of such insurance times the number of calendar months that have passed since the end of the month in which you reached age 65, including the month of your death. When your continuity of service terminates other than by death, the amount of your Life Insurance will be subject to immediate reduction to an amount which would have applied to you in accordance with the provisions set forth in the paragraph entitled "Benefits After Retirement or Termination of Employment at Age 65 or Later" had your service terminated at the end of the month in which you reached age 65.

In the event of your death from any cause, the amount of your Life Insurance then in force will be payable to the beneficiary designated by you. You may change your beneficiary at any time. Any designation of beneficiary or any change of beneficiary should be made in a form acceptable to the Insurance Company and must be filed with the records maintained by your employee relations or personnel accounting office. Upon request, such office will furnish you with a copy of your designation of beneficiary.

Upon receipt of written notice of change of beneficiary by such office, the change shall relate back and take effect as of the date you signed such written notice, whether or not you are living at the time of such receipt, but without prejudice to the Insurance Company on account of any payment made before receipt of such written notice.

If, at your death, there shall be more than one designated beneficiary, then, unless you shall have specified the respective interests of such beneficiaries, the interests of such beneficiaries shall be several and equal. If any designated beneficiary shall die before you, the rights and interests of such beneficiary shall thereupon automatically terminate. If at your death there is no beneficiary of

record as to all or any part of the insurance, then the amount of insurance payable for which there is no such beneficiary shall be payable to your estate, or the Insurance Company may, at its option, pay such amount to any one or more of the following surviving relatives: spouse, mother, father or child, which payment shall completely discharge all liability with respect to the amount of insurance so paid.

If your Life Insurance is payable in a lump sum to an adult beneficiary upon your death, the Company, in accordance with its normal policies, may make an adverse payment of up to $500 from the Life Insurance proceeds.

If you prefer, instead of having your Life Insurance paid in a lump sum, you may arrange to: (1) have it paid to your beneficiary in monthly or annual payments (a) over a fixed period of years or (b) during the lifetime of the beneficiary; or (2) have it held at interest for a limited period and then paid in a lump sum or in installments. If you wish, your beneficiary may elect any one of these optional modes of settlement in lieu of a lump sum settlement or in lieu of another optional mode which you may have elected during your lifetime. The Insurance Company will, from time to time, determine the minimum amounts of installments payable as well as the rate of interest to be used in calculating the amount of payments under the optional modes of settlement.

Benefits after Retirement or Termination of Employment at Age 65 or Later

If you retire from the Company on pension prior to age 65, or if you leave the service of the Company after you are entitled to optional retirement under the Company's Pension Plan, or if you leave on a retirement allowance granted by the Company, your Life Insurance will be continued in full force up to age 65.

Whether you retire prior to age 65 or your continuity of service terminates after age 65 or later, the amount of your Life Insurance will be reduced monthly, commencing on the first day of a calendar month following your 65th birthday, by an amount equal to 2½% of the total amount of Life Insurance in force on your life when you attained such age. These reductions will continue until the amount of Life Insurance is equal to the ultimate amount shown in the following table. If your death occurs after you reach age 70, up to the first $5,000 of the ultimate amount will be paid by the General Electric Insurance Plan Trust as a benefit in lieu of Life Insurance (the "Trust Death Benefits") and any portion of the ultimate amount which exceeds $5,000 will be paid by the Insurance Company as Life Insurance. However, if you or your spouse receives medical expense benefits in lieu of Life Insurance, as described on page 8, the ultimate amount will be further reduced by an amount equal to such medical expense benefits, and the reduced amount will be paid in accordance with the foregoing sentence. Notwithstanding any other provision of this paragraph, if (i) at age 70 you have made an irrevocable assignment of your Life Insurance, (ii) you have mandatorily deferred incentive compensation, or (iii) you retired from the General Electric Credit Corporation or one of its affiliates, your entire ultimate amount will be payable as Life Insurance.

ULTIMATE AMOUNT OF LIFE INSURANCE AFTER AGE 65 OR THE DATE OF YOUR RETIREMENT, IF LATER*

Period for which you have been insured immediately prior to age 65 or the date of your retirement, if later, under this Plan	Your ultimate amount of insurance **
10 years or more	33⅓% of your average amount of Life Insurance during the highest consecutive 5 years in the 10-year period
9 years	30% of your average amount of Life Insurance during the highest consecutive 5 years in the 9-year period
8 years	26⅔% of your average amount of Life Insurance during the highest consecutive 5 years in the 8-year period
7 years	23⅓% of your average amount of Life Insurance during the highest consecutive 5 years in the 7-year period
6 years	20% of your average amount of Life Insurance during the highest consecutive 5 years in the 6-year period
5 years	16⅔% of your average amount of Life Insurance for the 5-year period
Less than 5 years	0

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* Applicable to employees returning on or after July 1, 1973.

** The ultimate amount of insurance for any period between 5 and 10 years will be prorated to the nearest month at the rate of 3⅓% per year. In determining the average amount of Life Insurance as specified above, each amount of Life Insurance used in the calculation shall not be less than the amount which reflects the highest normal straight-time annual earnings during the five years immediately preceding the date as of which such amount is computed.

ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE

(For Employees)

(Occupational and Non-Occupational)

In addition to any other benefits which you as a participating employee may receive, the benefits in the following table will be paid for bodily injury, either on or off the job, caused solely by accidental means and, independently of all other causes, resulting in death or loss of hand, foot, or sight of eye. These benefits will be based on your normal straight-time annual earnings at the date of the accident. However, if at the time of the accident the amount of your Accidental Death or Dismemberment Insurance is based [omission in original exhibit].

The minimum weekly benefit is $35 for anyone with normal straight-time annual earnings of at least $3000.

Benefits will start with the eighth day you are totally disabled (or with the first day of your confinement in a hospital as a bed patient, if earlier) and will continue during your total disability up to a maximum period of 26 weeks for any one continuous period of disability or for successive periods of disability due to the same or related cause or causes.

If you are a salaried employee, benefits of $15 a week will be payable during any period of salary continuance commencing with the eighth day of total disability (or with the first day of confinement in a hospital as a bed patient, if earlier), and ending with the day upon which you shall have received, during the preceding 12 months' period, twenty days of salary continuance for personal illness or ending when such salary continuance shall earlier cease. Thereafter, if you are still disabled, the regular benefits described in the initial paragraphs of this section will become payable and will be paid during

the remainder of your total disability, but for not more than an additional period of 26 weeks.

If, after you return to work, you again become disabled (a) from the same cause following at least a 90 day period at work as determined by Company rules, or (b) from a different and unrelated cause, you again become eligible for full benefits.

Of course, to collect these benefits, you must be under the care of a physician for the treatment of your disability and your claim must be certified by a physician.

Benefit for Occupational Disabilities

You may be entitled to benefits under a Workers' Compensation or Occupational Disease Statute for occupational disabilities. However, if, during the period corresponding to that for which you would be paid Weekly Sickness and Accident benefits under this Plan if your disability were a non-occupational disability, the amount to which you are entitled under any Workers' Compensation or Occupational Disease Statute for time lost from work is less than the amount of benefits to which you would be entitled under this Plan for non-occupational disabilities, you will be paid the difference.

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

(For Employees and Dependents)
(Non-Occupational)

COMPREHENSIVE MEDICAL EXPENSE INSURANCE provided by this Plan for participating employees and for any of their covered dependents pays benefits for medical expenses as described below to the extent that such expenses are (1) for the diagnosis, care or treatment of non-occupational illness or injury, (2) reasonable, necessary, and customary and (3) for services performed or prescribed by a physician or surgeon, in a

hospital, at home, or elsewhere, including physician's or surgeon's services for consultation and confirming medical opinions. Such expenses are called Covered Medical Expenses and are of three types—Type A-1, Type A-2, and Type B.

For each covered individual, the lifetime maximum amount of benefits payable with respect to all his Covered Medical Expenses—Types A-1, A-2, and B combined—including any expenses for which benefits were paid under any prior General Electric Insurance Plan, is $350,000 in total, subject to reinstatement as described on page 7.

For the purpose of Comprehensive Medical Expense Insurance, an expense is deemed to have been incurred on the date the service is received or rendered.

Maternity Benefits

Benefits under Comprehensive Medical Expense insurance will be payable for covered medical expenses incurred by a participating employees or a covered dependent in connection with pregnancy, resulting childbirth or complications in connection therewith on the same basis as for any other disability. Such benefits also will be payable for any pregnancy which commences while insurance on account of such person is in force under this Plan.

Benefits for Type A-1 Covered Medical Expenses

Benefits on account of the Type A-1 expenses described below will be payable, for 365 days in each calendar year, at 100% of such expenses, for any one employee or any one covered dependent subject to the lifetime maximum amount specified on page 5.

1. Expenses incurred for room and board accommodations up to an amount equal to the full semi-private room rate, in (i) a legally constituted hospital or (ii) a

licensed detoxification facility upon the recommendation and approval of a physician for the treatment of alcoholism or drug addiction. Private room charges will be considered Covered Medical Expenses to the extent of the hospital's or facility's most common semi-private room rate, except that if confinement in a private room accommodation is medically required because of a contagious disease, as certified by a physician, the full pr' ate room rate will be paid.

2. Special hospital and detoxification facility services required for medical or surgical care or treatment, such as operating room, drugs, dressings, blood transfusions (including blood or blood plasma), oxygen and administration thereof, received during a hospital confinement of at least 18 hours in a hospital or detoxification facility. However, if because of an accident, emergency care is received in a hospital not later than the day following the injury, or if an operation is performed in a hospital, benefits on account of these special hospital services are payable even if the period of confinement is less than 18 hours.

3. Expenses incurred for room and board and special services at an ambulatory surgical facility.

4. Effective January 1, 1980, expenses incurred for room and board, special services and drugs and medical supplies in an extended care facility during a confinement which:

a. is for convalescent care which requires medical supervision and skilled nursing services,

b. commences within 14 days after termination of a period of covered hospital confinement which continued for at least 3 days and is ordered by a physician as necessary for convalescence from an illness or injury, or treatment of a terminal condition or a long-term disability, and

c. is for the same or related cause or causes as such period of hospital confinement.

The following services are not Covered Medical Expenses:

(i) in the case of private room accommodations, any charges in excess of the facility's most common semi-private room rate, and

(ii) custodial care

The maximum period for which extended care facility charges are included as Covered Medical Expenses is 120 days for the same or related cause or causes.

5. Effective January 1, 1980, expenses incurred in connection with a home therapy program, accredited by the National Hemophiliac Foundation and approved by the Insurance Company, for the treatment of a hemophiliac, while under the care of a physician.

6. Effective January 1, 1980, expenses incurred in an approved hospice care program for treatment of a terminally ill covered individual whose life expectancy approximates 6 months or less. The program must be accredited by the National Hospice Organization and approved by the Insurance Company. Treatment must be rendered and billed by the hospice care program and may be provided either in the hospice facility or in the individual's home, and also may include family counseling.

7. Effective July 1, 1980, expenses incurred for services rendered by a home health care agency approved by the Insurance Company for the following services and supplies furnished to a covered individual in such person's home in accordance with a home health care program provided such home health care commences within seven days following termination of a period of covered hospital or extended care facility confinement as a registered bed patient, and is for the same cause or a cause related to that for which such individual was so confined:

a. nursing care by or under the supervision of a registered graduate nurse,

b. home health aide services which consist primarily of caring for the patient,

c. physical therapy, occupational therapy, and speech therapy provided through the home health care agency,

d. medical supplies, drugs and medications prescribed by a physician, and laboratory services, and

e. medical social services rendered by a qualified social worker under the supervision of a physician.

The following services and supplies are not covered medical expenses:

(i) services of a person who ordinarily resides in the employee's home or is a member of the employee's immediate family,

(ii) services and supplies not related to medical care and treatment,

(iii) services rendered in any period during which the employee or dependent is not under the continuing care of a physician, and

(iv) custodial care.

Benefits for Type A-2 Covered Medical Expenses

Benefits on account of the Type A-2 expenses described below will be payable, during any one calendar year, at 100% of the first $500 of such expenses and at 85% of any additional expenses, for any one employee or any one covered dependent subject to the lifetime maximum amount specified on page 5.

1. Anesthetics and administration thereof—in a hospital, at home, or elsewhere.

2. Surgery performed by surgeons and assistant surgeons in a hospital, at home, or elsewhere.

Effective July 1, 1980, if a physician or surgeon has recommended a non-emergency surgical procedure for which benefits under this Plan would be payable, benefits will also be payable for expenses incurred in connection

with a second surgical opinion and expenses for any diagnostic x-rays and laboratory procedures in connection with such opinion, provided the physician or surgeon examines the patient in person and submits a written report to the Insurance Company. Benefits on account of expenses incurred for such a second surgical opinion will not be considered in determining the amount of other benefits payable during any one calendar year. Until July 1, 1980, surgery also includes dental surgery for:

a. Removal of an impacted tooth

b. Removal of a tooth root without extraction of the entire tooth (Apicoectomy)

c. Other cutting procedures on the gums and tissues of the mouth when not performed in connection with extraction, repair or replacement of teeth.

d. Extraction, removal of tooth, uncomplicated—including local anesthesia.

e. Extraction—multiple removal of teeth—including local anesthesia.

f. Extraction—odontectomy, soft tissue—including local anesthesia.

g. Alveolectomies

h. Pulp Capping

i. Vital Pulpotomy

j. Root Canal Filling

k. Anterior tooth; root canal filling with root-end amalgam.

l. Gingival Curettage

If you are participating in this Plan on June 30, 1980 and have less than one year of continuous service on that date, coverage for the above dental surgical procedures will continue until the earlier of the date you become covered under the General Electric Dental Assistance Plan or the date your Company service is terminated as determined by Company rules.

3. Local professional ambulance service.

4. Diagnostic X-Rays (and effective January 1, 1980, diagnostic imaging procedures), in a hospital, at home, or elsewhere.

Benefits for Type B Covered Medical Expenses

Benefits are payable on account of the Type B expenses described below which, during any one calendar year, are in excess of an initial amount of $50 for any one employee or any one covered dependent. Benefits will be 85% of all such expenses in excess of $50, subject to the lifetime maximum amount specified on page 5.

1. Services of physicians, including specialists, in a hospital, at home, or elsewhere.

If any of the services for the diagnosis, care or treatment of nonoccupational illness or injury for which benefits are provided under this Plan when performed or prescribed by a physician or surgeon, are rendered by a psychologist (as defined in this Plan) while acting within the lawful scope of his practice, benefits for such service will be provided on the same basis as if the service had been rendered by a physician or surgeon.

2. Services of registered graduate nurses—other than a nurse who ordinarily resides in the employee's home or who is a member of the employee's immediate family.

3. The following expenses, unless such expenses qualify as Type A-1 or A-2 expenses.

a. Diagnostic laboratory procedures

b. X-ray and radium treatments

c. Oxygen and administration thereof

d. Blood transfusions, including blood or blood plasma

e. Drugs and medicines requiring a physician's prescription and dispensed by a licensed pharmacist.

4. Rental of iron lung or other durable equipment required for therapeutic use.

5. Artificial limbs or other prosthetic appliances, except replacements of such appliances.

6. Expenses for the purchase of a hearing aid and expenses for examinations and the fitting thereof, within the limitations of:

a. only one such purchase in any thirty-six month period and,

b. expenses up to $300 in connection with any one such purchase,

excluding however, the replacement and repair of any part or parts of such hearing aid following such purchase.

7. Effective January 1, 1980, services of a Christian Science practitioner—other than a Christian Science practitioner who ordinarily resides in the employee's home or who is a member of the employee's immediate family—for actual visits for healing purposes provided such practitioner is accredited by the Mother Church in Boston, Massachusetts at the time of such visits.

Other Provisions

Benefits are determined separately for each individual. However, with respect to Type B Covered Medical Expenses, (a) if two or more covered members of a family should incur Covered Medical Expenses as a result of the same accident, the $50 initial amount referred to above will be applied only once against such Expenses during the calendar year in which the accident occurs, regardless of the number of family members injured; (b) the total initial amount of Covered Medical Expenses for which no benefits are payable will not exceed $125 for any employee and all his covered dependents in a calendar year, including any carryover as described in the following paragraph.

If any part or all of the initial amount of your own expenses for a calendar year arises from Type B Covered Medical Expenses incurred during the last three months of that calendar year, then that portion of such initial amount will be used to reduce the initial amount for the next calendar year. This provision will also apply to each of your covered dependents.

For mental or nervous conditions, the Plan will pay the benefits described on page 6 except that for Covered Medical Expenses incurred on account of psychiatric treatments or consultations while an employee is not totally disabled so as to be prevented from working or while a covered dependent is not confined in a hospital or similar institution, the rate of benefit will be 50% instead of 85% for Type B expenses.

If at any time benefits of at least $1000 have been paid for Covered Medical Expenses of a participant or covered dependent and evidence of the complete recovery and insurability of the person on whose account such benefits were paid is submitted to the Insurance Company, the amount of such benefits paid will not be included in determining the $350,000 lifetime maximum amount of benefits on account of such person on and after the date the Insurance Company accepts as satisfactory such evidence of insurability.

Effective January 1, 1980, if, during a calendar year, the combined unreimbursed Covered Medical Expenses of a participating employee and covered family dependents exceed $1,000, the Plan will pay 100% of all Covered Medical Expenses incurred thereafter by such individuals for the balance of that calendar year. Unreimbursed Covered Medical Expenses consist of the calendar year deductibles and the coinsurance portion of the Covered Medical Expenses which are payable by you, but do not include Covered Medical Expenses in excess of the lifetime maximum amount of benefits of $350,000 per covered individual.

In the event a participating employee or covered dependent is entitled to receive payment or reimbursement from any other person or persons as a result of legal action or claim (except against insurers on policies of insurance issued to the participating employee in his name or to any family member who ordinarily resides in his household) with respect to any expenses paid or reimbursed to him under this Plan, the Insurance Company shall be entitled to rights of subrogation against such other person or persons.

Exclusions

Expenses for the following are not Covered Medical Expenses under the Plan:

a. Expenses incurred by or on account of an individual prior to the effective date of the Plan as to him.

b. Expenses for dental services and appliances of any kind except expenses for hospital room and board and other special hospital services while a bed patient in connection with dental treatment. However, until July 1, 1980, (1) expenses for dental services and appliances required for correction of damage caused by accidental injury while insured, and (2) expenses for dental surgery to the extent provided on page 6 shall not be excluded provided such expenses otherwise qualify as Covered Medical Expenses. In the event you are participating in the Plan on June 30, 1980 and have less than one year of continuous service, coverage for the dental expenses in (1) and (2) above will continue until the earlier of the date you become covered under the General Electric Dental Assistance Plan, or the date your Company service is terminated as determined by Company rules.

c. Eye glasses, hearing aids and examinations for the prescription or fitting thereof. However, expenses for the purchase of a hearing aid and expenses for examinations and the fitting thereof shall not be excluded to the extent specified under Covered Medical Expenses.

d. Medical examinations or laboratory tests for check-up when not incident to treatment of injury or sickness.

e. Cosmetic surgery or treatment except to the extent necessary for correction of damage caused by accidental injury while insured.

f. Any services received because of sickness or injury arising out of or in the course of employment and entitling the employee or dependent to benefits under a Workers Compensation or Occupational Disease Law.

g. Services received in a hospital owned or operated by the United States Government, unless and to the extent that such hospital is specifically excepted from the limitations of this paragraph (g) by the Insurance Company on the ground that such hospital is the sole or virtually the sole source of hospital service for a community.

h. Services received for sickness or injury due to war (declared or undeclared) or any act of war, which act shall have occurred after the effective date of this Plan.

i. Expenses for which the individual is not required to make payment.

j. Expenses for which payment or reimbursement is received by or for the account of the individual as the result of a legal action or settlement (other than from a policy of insurance issued to the participating employee in his name or to any family member who ordinarily resides in his household).

k. Expenses to the extent of benefits provided under any employer group plan other than this Plan, except for any such employer group plan for which those insured under that plan are required to pay the full premium cost or subscription fee; also, expenses to the extent of benefits paid, or for which a covered individual is eligible to have paid upon proper application thereof under the Health Insurance for the Aged Act of the United States (Medicare).

However, the foregoing Exclusion (k) will be disregarded to the extent necessary to provide that, for all medical expenses incurred in a calendar year on account of the person for whom claim is made, the aggregate of the Comprehensive Medical Expense benefits payable under this Plan, together with the benefits payable or available (or the reasonable cash value of services rendered) under such other plan or plans, will equal the total amount of such medical expenses which are covered under any of the plans. Of course, the benefits under this Plan may not exceed those which would have been payable in the absence of the foregoing Exclusion (k).

In addition, the person claiming benefits shall furnish to the Insurance Company such information as may be necessary for the purposes of administering this provision.

l. Expenses to the extent paid, or which a covered individual is eligible to have paid upon proper application therefor, either directly or indirectly, under any other law, plan or program of any government, or any political subdivision thereof, of any country which provides medical care benefits, or under any plan, policy or contract, other than this Plan, if the cost thereof shall have been paid in whole or in part, either directly or indirectly, by the Company as the result of any such law, plan or program.

Covered Medical Expense Benefits after
Retirement or Attainment of Age 65

1. If you Continue to Work Beyond Your 65th Birthday

If you continue in Company employment beyond the end of the month in which you reach age 65, Comprehensive Medical Expense Insurance for yourself and your covered dependents will be continued until the date your service with the Company is terminated, provided you pay any required contributions.

The Company will reimburse you for the premium you pay for Medicare Part B for yourself provided you are enrolled for Medicare Part A and Part B. The first premium reimbursed will be that for the month in which you become eligible for and enroll for Medicare Part B and such reimbursement will be made only for the months during which coverage remains in force for you under this Plan and you continue to be enrolled for Medicare Part A and Part B .

On the date your service with the Company terminates, all Comprehensive Medical Expense Insurance for yourself and for your covered dependents will be discontinued except as provided in this and in the following paragraphs. If at that time, you or one or more of your covered dependents is totally disabled, Covered Medical Expense benefits will be continued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance.

If coverage for one or more of your dependents was not extended as provided in the preceding paragraph, and at the end of the month in which you retired from the Company on pension, you had (1) at least ten years of continuous service with the Company and (ii) been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you retired, you may elect to continue Comprehensive Medical Expense Insurance for your covered dependents, subject to the payment of the required contributions until:

a. with respect to insurance on account of dependent children, the date such person ceases to be a dependent, and

b. with respect to insurance on account of your spouse, the earlier of (i) the date your spouse becomes eligible for coverage under the Health Insurance for the Aged

Act of the United States (Medicare), because of age, or (ii) the date of your spouse's remarriage in case of your death.

Such insurance will then be discontinued except as provided in this and in the following paragraphs. If at that time one or more of your covered dependents are totally disabled, Covered Medical Expense benefits will be continued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance".

If you retire from the Company on pension, have at least ten years of continuous service with the Company which includes service after you reach age 65, and have been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you retire, insurance for medical expense will be provided under the Medical Care Plan for Pensioners (described below) for you (unless covered under this Plan) and your spouse (unless covered under this Plan or the Medical Care Plan for Pensioners on his/her own account) following the date of your retirement. In case either you or your covered dependent spouse is totally disabled when you retire, the benefits for you or your spouse specified in the paragraphs entitled "Medical Care Plan for Pensioners" will, for such disabled individual, become effective when the benefits provided under this Plan cease to apply.

2. If You Retire On or Prior to Your 65th Birthday

If you retire from the Company on pension prior to age 65, or if you leave the service of the Company after you are entitled to optional retirement under the Company's Pension Plan, or if you leave on a retirement allowance granted by the Company, Comprehensive Medical Expense Insurance for yourself and for your covered dependents will be continued until the end of the month in

which you reach age 65, provided you pay any required contributions.

At the end of the month in which you reach age 65, all Comprehensive Medical Expense Insurance for yourself and for your covered dependents will be discontinued except as provided in this and in the following paragraphs. If at that time, you or one or more of your covered dependents are totally disabled, Covered Medical Expense benefits will be continued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance".

If coverage for one or more of your dependents was not extended as provided in the preceding paragraph, and at the end of the month in which you reach age 65, you retired from the Company on pension and had (i) at least ten years of continuous service with the Company and (ii) been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you reach age 65, you may elect to continue Comprehensive Medical Expense Insurance for your covered dependents, subject to the payment of the required contributions until:

a. with respect to insurance on account of dependent children, the date such person ceases to be a dependent, and

b. with respect to insurance on account of your spouse, the earlier of (i) the date your spouse becomes eligible for coverage under the Health Insurance for the Aged Act of the United States (Medicare), because of age, or (ii) the date of your spouse's remarriage in case of your death.

Such insurance will then be discontinued except as provided in this and in the following paragraphs. If at that time one or more of your covered dependents are totally disabled, Covered Medical Expense benefits will be con-

tinued as described on page 10 under "Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance".

If you retire from the Company on pension and have at least ten years of continuous service with the Company and have been insured for Comprehensive Medical Expense Insurance under this Plan for as long as you were eligible during the 10-year period immediately prior to the end of the month in which you reach age 65, insurance for medical expenses will be provided under the Medical Care Plan for Pensioners (described below) for you (unless covered under this Plan) and your spouse (unless covered under this Plan or the Medical Care Plan for Pensioners on his/her own account) on the day following the end of the month in which you reach age 65. In case either you or your covered dependent spouse are totally disabled when you reach age 65, the benefits for you or your spouse specified in the paragraphs entitled "medical Care Plan for Pensioners" will, for such disabled individual, become effective when the benefits provided under this Plan cease to apply.

Medical Care Plan for Pensioners

The following benefits will be payable for you and your spouse subject to the maximum amount specified on page 8:

1. For Hospital confinements

a. $40 ($80, effective January 1, 1980) for the first day of confinement for which benefits are provided by Medicare (or would have been provided had the deductible been satisfied) and

b. $10 for each subsequent day of confinement for which benefits are provided by Medicare (or would have been provided had the deductible been satisfied) and

c. $40 for each day of confinement which extends beyond the 150 day period or such longer period for which

benefits are provided by Medicare, unless confined in a tuberculosis or psychiatric institution owned or operated by any government or agency thereof in which case the benefits in 2 below will be payable.

2. If confined in a tuberculosis or psychiatric institution owned or operated by any government or agency thereof or a portion of an extended care facility which qualifies for benefits under Medicare, $10 will be paid for each day of confinement which extends beyond the period for which benefits are provided by Medicare.

3. If not eligible for benefits under Medicare because of residence or travel outside of the United States or its possessions, or because of age, benefits are payable on account of Type A-1 or A-2 Covered Medical Expenses as described on page 6 (including the dental surgical procedures in effect on July 1, 1979) which, during any one calendar year, are in excess of an initial amount of $25 for you or for your spouse. Benefits will be 100% of the next $225 of such expenses and 85% of any additional expenses, subject to the maximum amount specified below.

The total amount of benefits payable for medical expenses on account of you and your spouse during the remainder of your lifetime after the end of the month in which you reach age 65 or the date of your retirement if you work beyond age 65 (or the later date described above with respect to total disability), whether for one cause or different causes will be limited to a total of $11,000 ($21,000, effective July 1, 1979) subject to the following provisions.

The first $10,000 ($20,000, effective July 1, 1979) of benefits will be payable by the Trustees of the General Electric Medical Care Trust for Pensioners (or in such other manner as may be elected by the Company). The remainder of the benefits will be paid under this Insurance Plan and, as such benefits are paid, a corresponding

reduction will be made in the ultimate amount payable under the Plan upon death, as described on page 4.

Furthermore, in the event of your death, your surviving spouse will have medical care benefits available equal to the remaining balance, if any, of the amount of such benefits available to you after the end of the month in which you reach age 65 or the date of your retirement, if you work beyond age 65, except for that part of the remaining benefit payment which would have reduced the amount of your Life Insurance.

If at the end of the month in which you reach age 65 or the date of your retirement, if you work beyond age 65, you have less than ten years of continuous service or are otherwise ineligible for the Medical Care Plan for Pensioners benefits described above, you may apply to the Insurance Company for an individual policy of Hospital Expense and Surgical Operation Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company for yourself or, if at that time you had insurance for your dependents under the Plan, you may apply for Hospital Expense and Surgical Operation Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company for yourself and your dependents, as described on page 10.

PENSIONERS PRESCRIPTION DRUG PLAN

If you are covered by the Medical Care Plan for Pensioners, effective January 1, 1980, you will be covered by the General Electric Pensioners Prescription Drug Plan which provides benefits for prescription drugs and medicines. Your spouse, unless covered under the General Electric Insurance Plan or the Medical Care Plan for Pensioners on his/her own account, will also be covered under the General Electric Pensioners Prescription Drug Plan when you become covered, if your spouse is age 65 or older on such date, otherwise, on the first of the month following your spouse's attainment of age 65. Coverage

of your surviving spouse, in the event of your death, will continue or will begin on the first of the month following your surviving spouse's attainment of age 65, if later. The benefits provided under the General Electric Pensioners Prescription Drug Plan will not be taken into account in connection with the lifetime limit of benefits under the Medical Care Plan for Pensioners for you and your spouse.

YOUR CONTRIBUTIONS FOR THE INSURANCE PLAN

Your contributions upon your enrollment for participation in the Plan will be as follows:

1. No contributions will be required for the full benefits of this Plan with respect to your employee coverage.

2. If you enroll for Comprehensive Medical Expense Insurance with respect to your dependents your contributions will be 2% of your normal straight-time annual earnings up to $5,000 of such earnings, a maximum contribution of $100 per year.

Any required contributions with respect to insurance on behalf of your dependents will be made by means of periodic payroll deductions from regular payments of compensation by the Company to you. If, on or after the date on which this Plan becomes effective as to you, you are laid off after you have three years of continuous service with the Company, you become totally disabled, or you begin an absence because of pregnancy, your contributions for dependent coverage will be waived as described on page 9. In the event you are laid off before you have three years of continuous service with the Company or are granted a leave of absence, contributions for your dependent coverage in an amount equal to the foregoing percentages of your normal straight-time annual earnings at the time of layoff or leave of absence, as the case may be, must be paid in monthly installments

in advance to the Company in order that your dependent coverage will be continued during such period.

If your normal straight-time annual earnings change any required contributions for dependents coverage under the Plan will increase or decrease in accordance with such change effective on the date such change is made if you are then actively at work or, if not, on the date you return to active work.

If you retire from the Company on Pension prior to age 65, or if you leave the service of the Company after you are entitled to optional retirement under the Company's Pension Plan, or if you leave on a retirement allowance granted by the Company, to keep your dependent coverage in force you will be required to continue your contribution for such coverage until you reach age 65, at the contribution rate in effect immediately prior to retirement, or to leaving the service of the Company.

The Company will pay the difference between the net cost of the Plan and the amount contributed by participating employees.

GENERAL PROVISIONS

Eligibility and Effective Date

All employees as defined on page 13 are eligible to participate in the Plan except (a) employees hired on a temporary basis, (b) individuals on retainer, and (c) other special classes of employees as prescribed by the rules of the Company from time to time.

If you are eligible to participate in the Plan, you will be covered under this Plan from your first day of actual work. An enrollment card for employee coverage should be completed so you may designate your beneficiary under the Life Insurance portion of the Plan.

You also may enroll for Comprehensive Medical Expense Insurance with respect to your eligible dependents.

Insurance for your dependents, if you enroll for that insurance, will become effective on the date you enroll but not before you become insured yourself as a participating employee. However, if on the effective date of the insurance for your dependents, a dependent is confined in a hospital or other institution for care or treatment or is confined at home under the care of a physician or surgeon because of a disabling physical or mental sickness or injury, coverage for that dependent shall not be effective until he or she has been discharged from the hospital or other institution, and is no longer confined at home under the care of a physician or surgeon.

Confinement of a newborn child will not postpone coverage for such child provided you are enrolled for insurance for your dependents at the time of the child's birth.

In the event that both you and your spouse are employed by the Company only one of you may enroll for dependent coverage on account of your child or children.

No Medical Examination

No medical examination for your dependents is necessary if you enroll on or before the date when you could first become insured with respect to your dependents or within thirty-one days thereafter.

If you do not enroll for insurance with respect to your dependents within thirty-one days of the date you first become eligible for such insurance or if such insurance ceases because you request cancellation of such coverage and you subsequently request reinstatement of such insurance, the Insurance Company may require that you provide satisfactory evidence of good health for each of your dependents at your own expense before you may become insured for such insurance. In such event, the coverage on account of each such dependent shall become effective on the date the Insurance Company accepts as satisfactory such evidence of good health of that dependent.

However, satisfactory evidence of good health of a dependent will not be required if you submit evidence which shows that the application for such dependent is being made within 31 days following the termination of medical expense coverage for that dependent under another employer group plan or under the General Electric Insurance Plan.

If both you and your spouse are employed by the Company, the thirty-one day period during which satisfactory evidence of good health for dependent coverage is not required begins on the earliest date either you or your spouse becomes eligible to enroll for dependent coverage.

Coverage for eligible dependents will be provided only by proper enrollment for such coverage, as described in the provisions set forth on pages 8 and 9.

Changes in Amounts of Insurance

If your normal straight-time annual earnings change so as to make you eligible for a different amount of insurance, your insurance under the Plan will increase or decrease in accordance with such change effective on the date such change is made if you are then actively at work or on paid vacation, if not, on the date of your return to active work.

Provisions Applicable If You Are Absent from Work

1. Total Disability

If you become totally disabled or if you cease work because of pregnancy on or after the date on which this Plan becomes effective as to you, your insurance, other than Weekly Sickness and Accident Insurance, will remain in force during a period of total disability of one week or more, up to a maximum period of one year (18 months in the case of occupational disabilities), but only as long as your continuity of service with the Company

is maintained, as determined by the Company's rules, subject to periodic proof of continuance of such disability. Insurance for your dependents will also continue in force under the conditions referred to in the preceding sentence, without further payment of contributions.

Weekly Sickness and Accident Insurance will be discontinued on the date you cease active work because of total disability or pregnancy, except that if you are entitled to Weekly Benefits for a disability existing on such date of cessation, Weekly Sickness and Accident Insurance will be continued until the expiration of the maximum period for which such benefits are payable for such disability in accordance with the provisions of the Plan. Such Insurance may be reinstated only upon your return to active work.

At the end of the maximum period referred to in the second preceding paragraph above or the termination of your continuity of service, whichever is earlier, all of the insurance provided by this Plan will cease, except as provided in this paragraph and on page 10. If before age 60 and while insured under the Plan, you had become totally disabled which, for the purposes of this paragraph only, means total disability as a result of bodily injury or disease so as to be wholly prevented thereby from engaging in any and every business or occupation and from performing any work for compensation or profit, your Life Insurance protection will be continued for the full amount until you reach age 65 provided you furnish proof satisfactory to the Insurance Company of the continuance of such total disability at least once each year. Commencing at age 65 the Life Insurance will be reduced gradually as provided on page 4.

2. Layoff or Leave of Absence

If you should be laid off or are granted a leave of absence (other than for military duty) on or after the date on which this Plan becomes effective as to you, your in-

surance, except for Weekly Sickness and Accident Insurance, will be continued up to a minimum period of one year, in the case of layoff or for the duration of your leave, but only as long as your continuity of service is maintained as determined by the Company's rules.

If you should be laid off after you have completed three or more years of continuous service with the Company (at the time of layoff) insurance for your covered dependents will be continued without payment of contributions (in layoffs of one week or more) up to a maximum period of one year, but only so long as your continuity of service is maintained as determined by Company rules.

If you should be laid off before you have three years of continuous service with the Company or if you are granted a leave of absence (other than for military duty), you may, upon payment of your regular contributions monthly in advance, continue insurance for your covered dependents, up to a maximum period of one year in the case of layoff but only as long as your continuity of service is maintained as determined by the Company's rules or for the duration of your leave of absence in case you are granted such a leave.

Benefits with respect to your Weekly Sickness and Accident Insurance will not be payable for any period of disability which begins more than 31 days after such layoff or leave of absence commences.

If insurance with respect to your dependents was discontinued during a period of layoff or leave of absence because of failure to make any required contributions for your dependent insurance, such coverage may be reinstated only upon your return to active work in accordance with the provisions under the caption "Eligibility and Effective Date."

If you leave for military duty, provision may be made with the Company for the continuation of the Life Insur-

ance provided by this Plan for a limited period. Notice will be given from time to time of the Company's practice as to the continuation of insurance for dependents of employees who leave for military duty.

3. Strike

If you cease work because of a strike, your insurance coverage and insurance for your covered dependents automatically will terminate on the day immediately preceding the first full day's absence from active work because of the strike. However, the Company may, in its discretion, make appropriate arrangements to continue your coverage under this Plan during such strike.

In any event, Weekly Sickness and Accident Insurance will not be continued beyond 31 days from the date last worked and will not be reinstated until you return to active work.

Retirement

Upon retirement on pension or otherwise, all of your insurance hereunder will be discontinued except to the extent that your Life Insurance and Comprehensive Medical Expense Insurance may be continued under the provisions beginning on pages 4 and 7. Individuals who leave the employ of the Company with vested rights under its Pension Plan are considered to have terminated employment rather than to have retired.

Group Practice Option

If you are enrolled for Comprehensive Medical Expense Insurance for yourself and any covered dependents and elect to receive medical care under a local group practice plan in lieu of Comprehensive Medical Expense Insurance provided by this Plan, you will receive a supplement outlining the effect on your coverage under this Plan and information concerning the financial arrangements.

Termination of Employment or Failure to Make Contributions

If your employment with the Company is terminated other than by retirement, and continuity of service, as determined by the Company's rules, is lost for any reason whatsoever, all insurance under the Plan will automatically cease on the date of such termination.

If you fail to make any required contributions when due, all insurance under the Plan for which contributions are required will automatically cease at the end of the period for which contributions have been paid.

In the event your employment terminated because of a plant closing, your employee coverage (except Weekly Sickness and Accident Insurance) and coverage for your dependents will be continued for one year beyond the date of the plant closing or your termination date if later except that if you have less than 3 years of continuous service at the date of plant closing your dependent insurance will be continued only if you make the required contributions monthly in advance. At the end of such period, the conversion privileges as described below will be available for 31 days after cessation of insurance. With respect to Weekly Sickness and Accident Insurance, benefits will not be payable for any period of disability which begins more than 31 days after your last day of work.

Special Provisions Applicable upon Discontinuance of Comprehensive Medical Expense Insurance

If you or one or more of your dependents are totally disabled when Comprehensive Medical Expense Insurance is discontinued, benefits are payable for that individual in accordance with the provisions of the Plan during the continuance of total disability, but not beyond the end of the calendar year following the calendar year in which such Insurance is discontinued.

During any period when, because of your total disability, benefits are provided for you pursuant to the pre-

ceding paragraph, Comprehensive Medical Expense benefits will also be provided for your dependents on whose account you were insured on the date your insurance was discontinued, and further provided that such dependents would otherwise continue to qualify as eligible dependents under this Plan.

When your benefits cease, either because of recovery or the expiration of the period specified in the preceding paragraphs, you may apply for a converted policy, as described on page 10, provided that application for such policy is made within 31 days after the date your benefits cease.

Life Insurance Conversion Privilege

Upon termination of your service with the Company they may arrange with the Insurance Company to continue you Life Insurance under an individual policy, without medical examination, if you make written application for it within 31 days after Life Insurance under the Plan ceases. The individual Life Insurance policy will be issued upon and one of the forms of policy then customarily issued to the Insurance Company (except Term Insurance and except policies containing provisions for Disability or Accidents Dealth Benefits), at the rate applicable to your class of risk and age at that time. However, at your opinion, such indidividual policy may be preceded by single premium term insurance for a period of one year. The amount of such individual policy will be equal to (or at your option less than) the amount of your Life Insurance in effect upon the date of your termination of service. Such individual policy will be effective at the end of the 31-day period, but if you should die during this period, the amount of your Life Insurance under the Plan will be payable to your beneficiary.

If your Life Insurance protection has been continued because of Total Disability (as described on page 9), the Life Insurance conversion privilege described above will

be available to you on the date you cease to be so totally disabled, provided you do not return to active work with the Company.

If an individual policy of Life Insurance has been issued pursuant to the foregoing paragraph, payment of any Life Insurance under this Plan will be made only if such individual policy is surrendered to the Insurance Company without claim. In such case, any premiums paid on such individual policy shall be refunded by the Insurance Company.

Health Insurance Conversion Privilege

If at the time of termination of your service with the Company, for any reason whatsoever, you are covered for Comprehensive Medical Expense Insurance under the Plan, you may arrange to obtain from the Insurance Company, without furnishing evidence of insurability, an individual policy for yourself or, if at that time you had insurance for your dependents under this Plan, an individual policy for yourself and such dependents, providing Hospital Expense Insurance or Hospital Expense and Surgical Operation Insurance or a similar type of policy then being issued for conversion purposes by the Insurance Company. The converted policy, which will include the provisions applicable to such forms of policy then being issued by the Insurance Company, may be obtained by making application to and paying the required premium to the Insurance Company within 31 days after cessation of your Comprehensive Medical Expense Insurance.

Your dependents may apply for conversion of their coverage if they do so within 31 days after their coverage if terminated unless such termination was at your request.

You or your dependents may obtain information concerning the individual policies currently available, and the applicable premium rates, as well as the proper ap-

plication form from your employee relations or personnel accounting office. (See reverse side of your certificate.)

Dependent Coverage after Employee's Death

If you should die while Comprehensive Medical Expense Insurance is in effect as to your covered dependents, such insurance will be continued in effect, without payment to contributions, for all covered eligible dependents for period of one year following the date of your death. At that time the Health Insurance Conversion Privilege described in the preceding paragraphs will be applicable to your covered dependents.

Payments of Benefits

Benefits for Type A-1 Covered Medical Expenses under the Plan are provided through Blue Cross of Massachusetts, Inc. Weekly Sickness and Accident Insurance benefits and Type A-2 and B Covered Medical Expenses are primarily payable from the General Electric Insurance Plan Trust, except that for California employees such benefits (as set forth in the applicable insert) and Expenses are provided by the Company and Aetna Life Insurance Company, respectively. Medical expense benefits after age 65 are provided as stated on pages 7 and 8 through the General Electric Medical Care Plan for Pensioners. Metropolitan Life Insurance Company is liable for all Life Insurance and Accidental Death or Dismemberment Insurance benefits under the Plan except that Puritan Life Insurance Company is liable for Life Insurance and Accidental Death Insurance benefits for employees of General Electric Credit Corporation and its affiliates, and the General Electric Insurance Plan Trust is liable for payment of Trust Death Benefits up to the first $5,000 of the ultimate amount for pensioners who die after reaching age 70, as described on page 4. Metropolitan Life Insurance Company also is liable for all Weekly Sickness and Accident Insurance and Comprehen-

sive Medical Expense Insurance benefits (other than Type A-1 Covered Medical Expenses and, for California employees, Weekly Sickness and Accident Insurance and Type A-2 and B Covered Medical Expenses) which are not payable from the General Electric Insurance Plan Trust.

Determinations of all benefit payments under the Plan will be made by Blue Cross of Massachusetts, Inc for Type A-1 Covered Medical Expenses, by Aetna Life Insurance Company for Type A-2 and B Covered Medical Expenses for California employees, by the Company for Weekly Sickness and Accident Insurance benefits for California employees, by Puritan Life Insurance Company for Life Insurance and Accidental Death Insurance benefits for employees of General Electric Credit Corporation and its affiliates and by Metropolitan Life Insurance Company for all other benefit payments.

Accordingly, the management and control of the operation and administration of claim procedures under the Plan, including the review and payment or denial of claims and the provision of full and fair review of claim denial pursuant to Section 503 of the Act, shall be vested in Blue Cross of Massachusetts, Inc., Aetna Life Insurance Company, the Company, Puritan Life Insurance Company, and Metropolitan Life Insurance Company, severally, with respect to that portion of the Plan for which each such entity determines benefits.

Claims for Benefits

Benefits under the Plan are payable upon receipt of proof of claim.

You should file claims promptly through such office as may be designated locally, such as your personnel accounting or employee relations office, for any benefits to which you may be entitled under the Plan upon forms which may be obtained locally. However, you are not required to submit claim forms for Type A-1 Covered Medical Ex-

penses. Proof of claim must be filed not later than 90 days (effective January 1, 1980, 180 days) after the end of the calendar year in which the loss for which claim is made is incurred unless it is not reasonably possible to do so and proof is filed as soon as is reasonably possible. The Insurance Company and General Electric Company, with respect to the benefits determined by them, reserve the right to medically examine an individual for whom claim is made.

Benefits for all Covered Medical Expenses billed by a hospital will be paid directly to the hospital. However, if at the time proof of claim is filed, evidence is submitted that such expenses have been paid, in whole or in part, the applicable benefit will be paid to you.

You Will Receive a Certificate

If required by law you will receive an individual certificate issued by the applicable Insurance Company to evidence the insurance benefits granted you as a participant under this Plan.

Amendment or Termination

This Plan may be amended, suspended, or terminated by the Board of Directors, in whole or in part, at any time without limitation, except as may be otherwise provided in collective bargaining agreements and except further that no such amendment, suspension, or termination shall adversely affect to a material degree any benefit payable with respect to any sickness, injury, or expense incurred prior to the effective date of such amendment, suspension, or termination, or affect the amount of life insurance and/or Trust Death Benefits for those employee who have retired, as described on page 4.

Federal or State Legislation Affecting the Benefits of this Plan

Some jurisdictions have laws with provisions for certain disability benefits.

If any such law is amended, or if any other legislation should be enacted which provides or requires benefits similar to those described in this booklet, appropriate modification will be made in the provisions of the Plan for individuals affected by such legislation.

Management and Control of Assets of Trust and Liability for Benefits

To provide benefits (the "Trust Benefits") for Life Insurance, Accidental Death or Dismemberment Insurance, Weekly Sickness and Accident Insurance (other than for California employees), Comprehensive Medical Expense Insurance and Trust Death Benefits as described on page 4 the Company has created the General Electric Insurance Plan Trust Said Trust, which is an irrevocable trust, is for the purposes of (a) receiving such sums of money for the funding of the payment of Trust Benefits as may from time to time be paid or delivered to the "Trustees by the Company and by employees or transferred to the Trustees by the Insurance Company, and investing and reinvesting the same, (b) entering into one or more insurance contracts with the insurance Company with respect to the Trust Benefits, and (c) making, or providing for payment of the Trust Benefits.

The Company will advance funds during each month, on behalf of the Trust, to pay Trust Benefits in accordance with the Plan and the directions and guidelines of, and the provisions of the policy or policies of insurance issued to the Trust by, the Insurance Company. In addition, before the end of each month, the Company will pay to the Trust the estimated amount required for insurance

premiums relating to the Trust Benefits for that month. Within 90 days after the end of each month for which such advances and payments were made, the Company shall pay to the Trust the aggregate of employee contributions and Company contributions (including contributions for insurance premiums), with respect to Trust Benefits, actually required for such month, and the Trust shall reimburse the Company for the advances made by the Company during such month.

The Trust Agreement provides, among other things:

a. that the Board of Directors has the power to amend or terminate the Plan and the Insurance Plan Trust at any time, in accordance with the provisions of the Plan and the Trust Agreement;

b. that the Committee has the power to appoint individual trustees, or to provide for a single corporate trustee or a corporate co-trustee, who shall have the sole and exclusive authority and discretion (except as otherwise expressly provided herein and in the Trust Agreement with respect to the power and authority of the Committee and the appointment of one or more investment managers) to manage and control the assets of the Trust; and

c. that the Trustees or Trustee may (i) make investments of any character, to the extent allowed by applicable law including investments in the securities, obligations or open accounts of the Company, (ii) enter into one or more insurance contracts with the Insurance Company, with respect to the Trust Benefits, (iii) if there are two or more Trustees, allocate among themselves, both singly and to one or more committees, each consisting of two or more Trustees, their powers, duties, obligations and responsibilities relating to management and control of the assets of the Trust, and (iv) appoint and discharge an investment manager or managers, as defined in the Act, to manage and control the assets of the Trust.

The Committee shall have the authority to direct the Trustees, both generally and specifically, with respect to

the management and control of the assets of the Trusts and may appoint and discharge one or more investment managers, as defined in the Act, with authority to manage and control the assets of the Trust. Except to the extent that the Committee shall have given directions to the Trustees or an investment manager or managers shall have been appointed to manage and control the assets of the Trust, the Trustees shall continue to have sole and exclusive authority and discretion to manage and control the assets of the Trust together with all of the obligations and responsibilities attendant upon such authority and discretion.

Administration

For purposes of the Act, General Electric Company shall be the Administrator of the Plan.

Any Named Fiduciary and any fiduciary designated by a Named Fiduciary may use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty of such fiduciary in connection with the Plan. Named Fiduciaries with respect to this Plan may allocate fiduciary responsibilities among themselves by written instrument signed in the same manner as provided for delegations in the next succeeding paragraph, and a written record shall be kept thereof.

Any Named Fiduciary may designate other individuals, corporations or other entities, who are not Named Fiduciaries, to carry out such Named Fiduciary's responsibilities, obligations and duties with respect to the Plan, except to the extent the Act prohibits delegation of authority and discretion to manage and control the assets of the Plan. Such delegations may be revoked or modified at any time and any such delegation, revocation or modification shall be made by written instruments signed by the Named Fiduciary, if an individual, or, in the case of other entities who are Named Fiduciaries, in accordance with

the procedures governing the functions of such entity, and a written record shall be kept thereof.

Any individual, corporation or other entity may serve in more than one fiduciary capacity with respect to the Plan.

No liability shall attach to or be incurred by the members of the Committee, the Trustees, or the stockholders, officers, directors or employees of the Company, in whatever capacity, under or by reason of the terms, conditions or agreements contained in the Plan, the Trust Agreement or any law, rule or regulation, or for acts or decisions taken or omitted by any of them thereunder. The fiduciary responsibilities of the Named Fiduciaries shall be exercisable severally and not jointly, and each Named Fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary by or in accordance with the terms of the Plan. Without limiting the generality of the foregoing, members of the Committee shall not be liable for any act or action, whether of commission or omission, of any Trustee or investment manager. Further, in the event of any delegation in accordance with the Plan, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. The provisions of this Paragraph shall be subject to the mandatory requirements of the Act.

DEFINITIONS

1. "Dependent"

The term "dependent" means (1) an employee's spouse and (2) any unmarried child under 23 years of age of an employee provided, however, that if the child is 19 years of age or over, the child is not employed full time and is principally dependent upon the employee for maintenance and support.

A child, wife or husband will not be considered a dependent if he or she either (a) is insured for medical expense benefits under any group plan of the Company, except as provided in the following sentence, (b) resides outside the United States and Canada, (c) is in the armed forces of any country, or (d) is required to submit evidence of good health and such evidence is not accepted as satisfactory by the Insurance Company. However, if an employee has retired, is age 65 or older, is no longer covered for Comprehensive Medical Expense Insurance and has a spouse who is employed by the Company, the spouse at work may cover the older spouse as a dependent.

The term "child" will mean (1) the employee's own children and legally adopted children, (2) step-children who reside in the employee's household, and (3) any other children supported solely by the employee and permanently residing in the household of which the employee is the head.

The age requirement for qualification as a dependent will be waived for a covered dependent child who, at attainment of age 23, is either:

a. A full-time student at school or college, or,

b. Incapable of self-sustaining employment for reason of mental illness or retardation or physical handicap. (Due proof of such incapacity shall be submitted by the employee to the Insurance Company whenever requested by the Insurance Company.)

Of course when any such child ceases to be a student, or if he recovers from his disability, coverage under this Plan for such child will automatically cease.

2. "Non-Occupational"

The term "non-occupational" means any sickness or injury not arising out of or in the course of employment and not entitling you or a covered dependent to benefits

under any Workers' Compensation or Occupational Disease Law.

3. "Physician" or "Surgeon"

The term "physician" or "surgeon" means a person legally licensed to practice medicine.

4. "Psychologist"

The term "Psychologist" means a person who meets one of the following qualifications:

(i) If practicing in a State or Province where statutory licensure or certification of psychologists exists, he holds a valid credential (as legally specified) for such practice;

(ii) If practicing in a State or Province where licensure or certification of psychologists does not exist, but where valid, nonstatutory (professional) certification is established by the jurisdiction's recognized psychological association, he holds such certification;

(iii) If practicing in a State or Province where neither statutory nor nonstatutory licensure or certification of psychologists exists, he holds a statement of qualification by a committee established for the purpose by the jurisdiction's recognized psychological association or, in the absence of such committee, he holds a diploma in the appropriate specialty awarded by the American Board of Examiners in Professional Psychology or its Canadian equivalent.

5. "Ambulatory Surgical Facility"

The term "ambulatory surgical facility" means a facility approved by the Insurance Company as meeting established criteria for handling surgical cases on a same day basis which would otherwise require hospital confinement.

6. "Extended Care Facility"

The term "extended care facility" means an institution which is primarily engaged in providing (a) skilled nursing care and related services for persons who require medical or nursing care, and (b) rehabilitation services for the rehabilitation of injured, disabled or sick persons, provided that such institution:

(i) is accredited by the Joint Commission on Accreditation of Hospitals as an extended care facility or is recognized under the Health Insurance for the Aged Act of the United States (Medicare) as an extended care facility; and

(ii) is not, other than incidentally, a place for rest, for domiciliary care, for the aged, for the blind, for the deaf, for the mentally deficient, or for persons suffering from tuberculosis, or a hotel or motel.

7. "Home Health Care Agency"

The term "home health care agency" means (a) a legally constituted hospital possessing a valid operating certificate issued in accordance with a public health law authorizing the hospital to provide home health care services, or (b) a home health care service agency possessing a valid certificate issued in accordance with a public health law, or similar legally valid credential, authorizing such organization or agency to provide home health care services.

The term "home health care program" means a program established and approved, including any modifications as later may be necessary, by a physician within seven days following termination of a period of covered hospital or extended care facility confinement as a registered bed patient, together with such physician's certification that the medical condition of the covered individual and the proper treatment of the specific condition would require continued confinement as a bed patient in a hospital or extended care facility in the absence of the services and

supplies provided as part of the home health care program.

8. "Group Practice Plan"

The term "group practice plan" means a health maintenance organization which under the Federal Health Maintenance Organization Act or under a similar state law which regulates health maintennace organizations is:

(i) certified as qualified to operate; and

(ii) required to be offered to eligible employees and their dependents.

9. "Company"

The term "Company" means General Electric Company and any affiliate.

10. "Board of Directors"

The term "Board of Directors" means the Board of Directors of General Electric Company.

11. "Affiliate"

The term "affiliate" means Electrical Mutual Liability Insurance Company and any corporation whose voting stock is owned in whole or in part, directly or indirectly, by General Electric Company.

12. "Employee"

The term "employee" means (a) any employee of General Electric Company or of any affiliate if such affiliate elects to participate in this Plan and if its participation is accepted by the Chief Executive Officer of General Electric Company or by such person or persons as he may designate, and (b) any employee of any affiliate who is designated for participation in this Plan, with approval

of the Insurance Company, by the Chief Executive Officer of General Electric Company or by such person or persons he may appoint.

13. "Insurance Company"

The term "Insurance Company" means Blue Cross of Massachusetts, Inc. with respect to Type A-1 Covered Medical Expenses, Puritan Life Insurance Company with respect to Life Insurance and Accidental Death Insurance for employees of General Electric Credit Corporation and its affiliates, Aetna Life Insurance Company with respect to Type A-2 and B Covered Medical Expenses for California employees, and Metropolitan Life Insurance Company with respect to all other benefit coverage under the Plan except Weekly Sickness and Accident Insurance benefits for California employees.

14. "Normal Straight-Time Annual Earnings"

Except as hereinafter provided in this paragraph, the term "normal straight-time annual earnings" means the amount which an employee is earning as salary or wages from the Company at the applicable time or was earning when last actively at work for the Company, extended to an annual basis, and shall include night shift bonus and cost of living adjustment. To such extent as the Pension Board may provide, the term "normal straight-time annual earnings" may include commissions, other variable compensation, and any special or supplemental payments; provided, however, that "normal straight-time annual earnings" shall not include payments for overtime (straight-time and premium). Where any inclusions in "normal straight-time annual earnings" are paid at times less frequent than an employee's regular payroll periods, the Pension Board may determine the compensation base to be used for both contributions and insurance benefits for periods prior to the determinations of the actual amounts of such inclusions. However, for purposes of

determining the highest amount of Life Insurance and Accidental Death or Dismemberment coverage during a preceding five year period, normal straight-time annual earnings used for such calculation will include commissions, other variable compensation, and any special or supplemental payments only to the extent expressly authorized by the Pension Board for such purposes.

In accordance with the foregoing definition, an employee's normal straight-time annual earnings shall be determined as follows:

1. In the case of

a. Hourly Rated Employees

52-1/6 times the employee's straight-time hourly wage times the number of hours in the employee's normal work week up to 40 hours per week.

An incentive worker's normal straight-time hourly wage shall be determined by the Company in accordance with its normal practices and shall be based upon the latest periodic earnings statistics where such statistics are available.

b. Salaried Employees

(i) Weekly rate—52-1/6 times the employee's regular weekly salary

(ii) Semi-monthly rate—24 times the employee's regular semi-monthly salary

(iii) Monthly rate—12 times the employee's regular monthly salary.

2. In other cases, in accordance with the Company's normal practices consistent with the above.

The Company's determination of an employee's normal straight-time annual earnings in accordance with the foregoing shall be final and conclusive and binding upon any person having any interest in this Plan.

15. "Normal Straight-Time Weekly Earnings"

An employee's normal straight-time weekly earnings shall be determined by dividing his normal straight-time annual earnings by 52-1/6.

16. "Company rules" or "Company practices"

Where reference is made in this Plan to Company rules or practices, such rules or practices shall be those in general effect in the Company and in the case of an employee covered by a collective bargaining agreement shall conform to any applicable provision of such agreement.

17. "Committee"

"Committee" means the Committee as defined in the General Electric Pension Plan.

18. "Named Fiduciary"

The term "Named Fiduciary" means any fiduciary with respect to the Plan who is either named in the Plan or who is appointed by the Company in writing.

19. "Fiduciary"

"Fiduciary" shall have the same meaning the term fiduciary has in the Act.

20. "Act"

The term "Act" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

GROUP INSURANCE CERTIFICATE

AETNA LIFE INSURANCE COMPANY
Hartford, Connecticut

(Herein called the Insurance Company)

HEREBY CERTIFIES that Group Policy No. H-57267 has been issued to General Electric Company under which you are insured for the Comprehensive Medical Expense Benefits described in the

GENERAL ELECTRIC INSURANCE PLAN

As Set Forth In The Preceding

Certificate-Booklet Form ERB 201D

If you are an Employee, as defined in the Certificate-Booklet, you will become insured for Comprehensive Medical Expense Benefits in accordance with the provisions set forth in the Certificate-Booklet under the caption "Eligibility and Effective Date".

If you enroll for such insurance within thirty-one days of the date of your initial eligibility, your insurance will become effective on the date of enrollment if you are then at work. If such enrollment is made after such thirty-one day period, you must furnish (without expense to the Insurance Company) evidence of insurability satisfactory to the Insurance Company before you may become insured. If such evidence is submitted, you will become insured on the date the Insurance Company determines the evidence to be satisfactory. In any instance when you are both disabled (i.e., ill or injured) and away from work on the date you would become insured in accordance with the terms of this paragraph, the effective date of your insurance will be deferred until your return to active work.

The insurance providing the Comprehensive Medical Expense Benefits on account of your Dependents is appli-

cable only if you are eligible, have enrolled, and are insured, for such insurance.

There is certain further information relating to your insurance on the next page of this Certificate.

AETNA LIFE INSURANCE COMPANY

/s/ William O. Bailey
President

If Any Prior Certificate Relating to the Insurance
Referred to Herein Has Been Delivered to the
Employee Referred to Herein
Such Certificate is Void

ASSIGNMENT

The insurance and benefits evidenced in this Certificate are non-assignable except with respect to benefits payable for a loss incurred.

HEALTH INSURANCE CONVERSION PRIVILEGE

In the event of cessation of your Comprehensive Medical Expense Insurance because of termination of your service with the Company for any reason, you may arrange to obtain from the Insurance Company, without furnishing evidence of insurability, an individual policy for yourself or, if at that time you had insurance for your dependents under the Insurance Plan, an individual policy for yourself and such dependents in accordance with the following conditions. The individual policy may provide, at your option, Hospital Expense Insurance, or Hospital Expense and Surgical Operation Insurance or Comprehensive In-Hospital Insurance or similar type of policy then being issued for conversion purposes by the Insurance Company subject to the requirements of any applicable laws and regulations relating to the issuance of such insurance. The individual policy may be obtained by making application to and paying the required premium to the Insurance Company within thirty-one days after cessation of your Comprehensive Medical Expense Insurance, and shall become effective upon cessation of such insurance under the Plan.

At the option of the Insurance Company, the individual policy need not provide maternity benefits, nor benefits in excess of those under your Comprehensive Medical Expense Insurance. The individual policy may provide (a) for the exclusion of any condition excluded by your Comprehensive Medical Expense Insurance but not any other pre-existing condition; (b) for reduction of benefits thereunder during the first year to the extent that benefits will not exceed those that would have been provided had your Comprehensive Medical Insurance not

ceased; and (c) for reduction of benefits thereunder by any benefits payable under your Comprehensive Medical Expense Insurance after such insurance has ceased.

The Insurance Company will not be required to issue the converted policy covering any person if it is indicated that, at the date of termination he has similar coverage, or is eligible on a group basis for similar coverage, which together with the converted policy would result in overinsurance or duplication of benefits. The converted policy may provide that the Insurance Company may request, on any premium due date of such policy, information concerning the existence of similar coverage on any person covered thereunder, and if any such person fails to furnish details of such coverage when requested may take such coverage into account in determining benefits payable under the converted policy.

Your dependents may apply for individual policies under the same conditions as you, if they do so within thirty-one days after their coverage is terminated unless such termination was at your request.

You or your dependents may obtain information concerning the individual policies currently available for conversion purposes, and the applicable premium rates, as well as the proper application form, from your employee relations or personnel accounting office.

NOTICES TO EMPLOYEE

This Certificate and your Certificate-Booklet are valuable to you and you should keep them in a safe place. If you lose your Certificate-booklet, an additional copy may be obtained from your employer.

If you cease active work for any reason, you should find out from your employer what arrangements, if any, can be made to continue your insurance benefits in force, so that you will be able to exercise any rights you may then have.

The Home Office of the Insurance Company is located at 151 Farmington Avenue, Hartford, Connecticut 06156.

COMPREHENSIVE INSURANCE
California Supplement

Self-Insured Voluntary Plan

For Payment of Disability Benefits to
California Employees
Under Division I, Part 2
Of California Unemployment Insurance Code

Notice for California Employees

You will receive a separate document which sets forth the provisions of the Self-Insured Voluntary Plan for payment of disability benefits to California employees, if you are a California employee of General Electric Company or of a Company affiliate which provides the Self-Insured Voluntary Plan for its California employees.

General Electric Insurance Plan

To Our New Jersey Employees:

Plan ERB-201D sets forth the General Electric Insurance Plan as amended June 28, 1976. In accordance with the New Jersey Temporary Disability Benefits Law, the Plan includes Weekly Sickness and Accident Benefits payable under the Company's "Private Plan" of Temporary Disability Benefits which is outlined below. As a New Jersey employee your weekly benefit will not be less than an amount equal to two-thirds of your average weekly wage to a maximum weekly benefit of $117.00.

Because certain benefits provided under the "Private Plan" are not available to employees in other states, you will be required to contribute $.64 per month in addition to any contribution required under the General Electric Insurance Plan.

"Private Plan" of Temporary Disability Benefits

This notice outlines the "Private Plan" established in accordance with the Temporary Disability Benefits Law of the State of New Jersey. The benefits provided by the "Private Plan" are underwritten by the Metropolitan Life Insurance Company.

In compliance with the Temporary Disability Benefits Law of the State of New Jersey, as amended effective January 1, 1979, the following Weekly Benefits for disabilities commencing on and after January 1, 1979, are available under the "Private Plan" while you are employed by the Company and for the first two weeks thereafter, but in no event beyond the date you become employed by another covered employer.

Class	Weekly Benefit (See Note)
All Employees	The amount of Weekly Benefits shall be an amount equal to two-thirds of the Employee's average weekly wage * with a minimum Weekly Benefit of $10.00 and a maximum Weekly Benefit of $117.00. Such Weekly Benefit shall be computed to the next higher multiple of $1.00 if not already a multiple thereof.

* If the Employee's normal straight-time weekly earnings are $57.51 or more, the amount of Weekly Benefit shall not be less than $35.00.

The maximum Weekly Benefits specified above is applicable to periods of disability commencing in the calendar year 1979. Employees will be notified as of January 1 of each succeeding calendar year of the maximum Weekly Benefit applicable to periods of disability commencing in such year.

Note:—In the case of Salaried Employees the Weekly Benefit shall be:

(i) $15.00 during any period of disability while the Employee receives his regular remuneration during

absence from active work and prior to the day following (a) the day on which payment of such regular remuneration shall cease or (b) the day as of which such regular remuneration shall have been so paid to the Employee for twenty days in the preceding twelve months, whichever day first [occurs; and]

(ii) with respect to any other period of disability, an amount determined in accordance with the Schedule above.

Benefits payable while the $15.00 Weekly Benefit rate is applicable shall not be included in determining the maximum period for which Weekly Benefits are payable pursuant to the second following paragraph.

Any change in the amount of the Employee's insurance shall become effective in accordance with the provisions of the Group Policy, but in no case shall any change become effective on a date on which the Employee is not actively at work.

Benefits will start with the 8th day you are disabled as a result of sickness, accident or pregnancy (or with the 1st day of your confinement in a hospital as a bed patient, if earlier), and will continue during such disability up to a maximum of 26 times your weekly benefit rate. In addition, if weekly benefits for any one continuous period of disability are paid for three consecutive weeks, then benefits shall be paid from the first day of that period of disability.

In order to qualify for "Private Plan" benefits you must:

1. Be totally unable to perform the duties of your employment.
2. Be under treatment by a legally licensed physician, dentist, chiropodist or chiropractor.
3. Not be working for remuneration during your disability.

4. Not eligible for benefits for the same disability under any Worker's Compensation or Occupational Disease Law, or under any unemployment compensation or similar law.

If you cease work because of a strike, benefits shall not be payable for any period during which you would be disqualified from receiving benefits under subsection (i) of Section 15 of the New Jersey Temporary Disability Benefits Law if you were not covered under a Private Plan. However, the Company may, in its discretion, make appropriate arrangements to continue your coverage under this Plan during such strike.

The benefits described herein conform in all respects with the New Jersey Temporary Disability Benefits Law, and will never be less liberal than the benefits otherwise provided by said Law. You will receive a certificate to evidence the benefits granted you under the provisions of this "Private Plan."

GENERAL ELECTRIC COMPANY

Supplement ERB 199E/201 DW-3
Supplement ERB 199H/201 DW-3
Supplement ERB 199N/201 DW-3

General Electric Insurance Plan

To Our New York Employees:

Effective January 1, 1979, the following provisions replace the provision appearing in Supplementary Insert Form ERB-201D-X-1 of Certificate Booklet Form ERB-201D:

Plan ERB-201D sets forth the General Electric Insurance Plan as amended June 28, 1976. The level of Weekly Sickness and Accident benefits provided by this Plan is in excess of that required by the New York Disability Benefits Law.

In accordance with the provisions of such Law and notwithstanding any other provisions of the Plan, Weekly Sickness and Accident coverage under the Plan is continued for a period of four weeks after your employment terminates, but in no event beyond the fifth day of such period on which you perform any work for remuneration or profit or the first day on which you perform work for any employer covered by the Disability Benefits Law.

Because this Plan provides benefits, as required by the New York Disability Benefits Law, that are not available to employees in other states, you will be required to contribute 13¢ per month in addition to any contributions required under the General Electric Insurance Plan.

GENERAL ELECTRIC COMPANY

Supplement Insert ERB 199E/201 D-X-2
Supplement Insert ERB 199H/201 D-X-2
Supplement Insert ERB 199N/201 D-X-2

General Electric Insurance Plan

To Our Rhode Island Employees:

Effective January 1, 1979, the following provisions replace the provisions appearing in Supplementary Insert Form ERB-201D-Y of Certificate Booklet Form ERB-201D:

Plan ERB-201D sets forth the General Electric Insurance Plan as amended June 28, 1976. For our Rhode Island employees, the Weekly Sickness and Accident benefits shown in the booklet will continue to be modified as follows to take into consideration benefits of a similar type provided under the Rhode Island Temporary Disability Insurance Act.

The Weekly benefits provided by the Insurance Plan will continue to be reduced by the actual amount of Rhode Island benefits payable (including any dependent allowance) for any disability.

Deductions will continue to be made for coverage under the Rhode Island Temporary Disability Insurance Act effective January 1, 1979, at the rate of 1½% on the first $4,800 of earnings. However, these deductions will be reduced by a credit which will be provided by the Company so that the maximum deduction will be $9.40 in 1979 and subsequent years. This credit is provided so that Rhode Island employees will be on an equitable basis with the employees in other states with respect to the General Electric Insurance Plan.

GENERAL ELECTRIC COMPANY

Supplement Insert ERB 199E/201 D-Y-1
Supplement Insert ERB 199H/201 D-Y-1
Supplement Insert ERB 199N/201 D-Y-1

EXHIBIT 9

AGREEMENT

on

EMPLOYEE BENEFIT

PROGRAMS dated September 6, 1976

between

The B.F. Goodrich Company

and

International Union of
The United Rubber, Cork,
Linoleum, and Plastic
Workers of America
AFL-CIO-CLC

and

Local Unions

No. 5, Akron, Ohio
No. 715, Ft. Wayne, Ind.
No. 241, Marion, O.
No. 351, Tuscaloosa, Ala.
No. 318, Miami, Okla.
No. 281, Oaks, Pa.

[UNION LABEL]

Article 12 (Cont.)

* * * *

customary charges therefor or in excess of such charges as would have been made in the absence of this program. A customary charge means the usual charge made by the person, group or other entity rendered or furnishing the services, treatments or supplies but in no event will it mean a charge in excess of the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for illnesses comparable in severity and nature to the illness being treated. The term "area" means a county or such greater area as is necessary to obtain a representative cross section of persons, groups or other entities rendering or furnishing such service, treatment or supply.

(d) Mental, Psychoneurotic or Personality Disorder Conditions: As to Covered Expenses resulting from mental, psychoneurotic or personality disorders incurred while the Family Member is not confined in a hospital on an inpatient basis, any benefit payable with respect to such expenses after the deductible will only be included to the extent of $30.00 for professional services rendered during each such visit, and will be at the rate of 50% subject to a seven hundred fifty ($750.00) dollars calendar year Maximum Benefit.

(i) Covered Expenses shall include charges actually made to a Family Member for services of a clinical psychologist in connection with the diagnosis or treatment of any mental, psychoneurotic or personality disorder of such Family Member which would apply if such services were rendered by a physician.

(ii) "Clinical psychologist" means a person who provides clinical psychological services in connection with the diagnosis or treatment of mental, psychoneurotic or personality disorders, and who qualifies as a psychologist, in any of the following ways in the jurisdiction (state, District of Columbia, territory or possession of the United States, or province of Canada) in which he is practicing:

If statutory licensure or certification of psychologists exists in the jurisdiction, he holds a valid license or certificate of such jurisdiction as a psychologist.

If statutory licensure or certification of psychologists does not exist in the jurisdiction, he holds a valid, non-statutory (professional) certification established by the jurisdiction's recognized psychological association.

EXHIBIT 10

ARTICLE 12—Continued

12.7 (c) (v) (Continued)

(a) No change

(b) No change

(vi) No change

(vii) No change

(d) Amend to read as follows:

Mental, Psychoneurotic or Personality Disorder Conditions: As to Covered Expenses resulting from mental, psychoneurotic or personality disorders incurred while the Family Member is not confined in a hospital on an inpatient basis, any benefit payable with respect to such expenses after the deductible will only be included to the extent of $50.00 for professional services rendered during each such visit, and will be at the rate of 50% subject to a one thousand ($1,000.00) dollars calendar year Maximum Benefit.

(i) No change

(ii) No change

(e) 1st paragraph—No change

2nd paragraph—amend to read as follows:

Room and board in an approved Convalescent Nursing Home, and other services and supplies furnished by an approved Convalescent Nursing Home for Medical care, exclusive of professional services will be considered covered expenses if

the covered individual has been confined in a hospital for at least three (3) days and then admitted to such Convalescent Nursing Home following the hospital confinement upon the written recommendation of the attending physician certifying that the patient's condition would require hospital confinement if Convalescent Nursing Home care were not available. Readmission, upon the attending physician's recertification, to such Convalescent Nursing Home following discharge will be considered a continuation of the same confinement for purposes of this Paragraph.

EXHIBIT 11

12.3(a)(v)	Add two new procedures in lieu of surgery: Immunotherapy for malignant disease Ultransonography
12.4	Increase amounts from $18 to $25 and from $12.50 to $17 for in-hospital doctors' visits.
12.7(b)	Increase Major Medical limits from $50,000 to $75,000 annual maximum and from $200,000 to $300,00 lifetime maximum.
12.7(d)	Increase allowances for mental/psychoneurotic outpatient treatment from $30 to $45 per visit and from $750 to $1,125 annually.
12.7(k)(1)(b) and 12.7(k)(1)(c)	Revise retiree Major Medical Deductible provisions to be compatible with changes in 12.15(h), Special Medicare Benefit.
12.9(c)	Amend to reflect change in 12.10.
12.10	Amend to provide 24 months of continued Company-paid medical coverage in the event of Plant Closure.
12.13(a)(4)	Provide automatic coverage of spouse and dependents for medical benefits if employee dies after attaining 25 years of service, regardless of age. Under the 1976 Agreement, such coverage was available only to employees eligible for retirement.
12.14	Language revised to allow coverage for newly acquired spouse and dependents of a retiree who marries, or remarries, after retirement. In the event of the retiree death, coverage to the new spouse and dependents continued only if married for one year, or more.

12.15(c)	Add "Chiropractor" to definition of physician.
12.15(h)	Employees who are age 65 or over; eligible surviving spouses and employees otherwise eligible for Medicare Part B will automatically receive the Special Medicare Benefit.
12.16(f)	Provides co-ordination of benefits with Medicare for any Pensioner, employee, or dependent on whose behalf the Special Medicare Benefit was paid.
ARTICLE 13	Sickness and Accident Program
13.1	Increase amount of Sickness and Accident Benefits from $110 to $125 per week.
13.2	Provide for benefits to be payable for pregnancy or related conditions the same as for any other medical condition, removing the maximum of six weeks of payments.
13.10(c)	Add language to allow a Chiropractor acting within the scope of his license, to certify a disability under the Sickness and Accident Program.

EXHIBIT 12

AGREEMENT

between

GTE SYLVANIA, INC.
for its Loring Avenue,
Salem, Massachusetts, Plants

and

INTERNATIONAL UNION OF
ELECTRICAL, RADIO & MACHINE
WORKERS, IUE (AFL-CIO)

September 3, 1973 through
November 15, 1976

[UNION LABEL]

APPENDIX

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Schedule "B"

General Wage Increases 70

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Termination Pay for Plant Closing 83

Schedule "D"

Employee Group Insurance and Benefit Plan 85

* * * *

"Covered medical expenses", when used in this Section for covered disabilities shall mean reasonable charges for medical services when required in the treatment of an illness. With respect to such services necessarily rendered in the hospital, such term shall include: (1) all room-and-board charges up to a maximum of $6.00 per day above the hospital's most common semi-private room rate and (2) all miscellaneous charges made by the hospital. With respect to such services which may be rendered either in or out of a hospital, such term shall include: (1) Physician's services for surgical and medical care and treatment; (2) nursing care by a trained nurse (one who has sufficient training in the opinion of the attending physician to care for the patient) when ordered by physician, except a nurse who is a relative or one who lives in an employee's home unless she is actively on the applicable registry and she is assigned to the case in accordance with the usual procedure; (3) emergency transportation services (within the United States of America and Canada) by ambulance, regularly scheduled airline or railroad from the point where disabled, to or from a hospital qualified to provide special treatment for the condition, but not more than one trip to and one trip from the hospital in any one benefit period on account of any one accident or sickness; (4) x-ray examination and x-rays, radium and radioactive isotope treatments and laboratory tests or analyses if incurred upon the recommendation and approval of the attending physician; (5) anesthetic and its administration if incurred upon the recommendation and approval of the attending physician; (6) prescription drugs, bandages, surgical dressings, surgical supplies, oxygen and rental of equipment to administer oxygen, rental of wheel chair or hospital type bed and rental of iron lung or other equipment for treatment of respiratory paralysis if incurred upon the recommendation and approval of the attending physician; (7) blood, plasma and cost of administration if incurred

upon the recommendation and approval of the attending physician; (8) charges incurred on account of nervous or mental disorders while a person is confined in a hospital; (9) charges up to $12.50 per visit for no more than fifty visits with respect to a benefit period incurred for out patient psychiatric care and treatment of a disability provided that such treatment is rendered by a licensed psychiatrist; (10) charges incurred for Caesarean section and operation for extra-uterine pregnancy and subsequent expenses incident thereto and charges incurred for severe medical or surgical complications arising out of pregnancy, childbirth or miscarriage and subsequent expenses incident thereto, over and above the charges actually incurred for miscarriage, normal pregnancy, or normal childbirth; provided, that such charges shall be included only in the event the person is entitled to maternity benefits under the Basic Medical coverage referred to in Section D hereof; and provided further, that no other charges incurred in connection with pregnancy, childbirth or miscarriage shall be included; (11) charges incurred in connection with any dental work or procedures, eye refraction, eye glasses, hearing aids or the fitting thereof which are required on account of accidental bodily injury to physical organs or parts, sustained while the person is insured hereunder and (12) dental surgery procedures covered under Basic Medical Insurance referred to in Section D hereof.

* * * *

EXHIBIT 13

AGREEMENT

between

GTE SYLVANIA
INCORPORATED
for its Loring Avenue,
Salem, Massachusetts, Plants

and

INTERNATIONAL UNION OF
ELECTRICAL, RADIO & MACHINE
WORKERS, IUE (AFL-CIO)

September 10, 1976
through
November 15, 1979

[Union Label]

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Employee Group Insurance and Benefit Plan 76

* * * *

11) The schedule of procedures for the diagnostic procedures benefit shall be increased to double the present schedule with a maximum of $150 for any and all sicknesses.

The outpatient psychiatric benefit for employees only shall be improved to provide:

a) payment for the full cost of the first two visits to a clinic or psychiatrist based on reasonable charges,

b) payment of $34.00 for remaining visits to a psychiatrist or $17.00 for clinics.

c) that payment for visits to a clinic or psychiatrist will be limited to the first two visits mention in a) above and an additional fifteen visits mentioned in b) above per twelve month benefit period.

d) that a "clinic" will qualify for coverage only if it is affiliated with a state licensed hospital.

* * * *

EXHIBIT 14

AGREEMENT

between

GTE SYLVANIA
INCORPORATED
for its Loring Avenue
Salem, Massachusetts, Plants

and

INTERNATIONAL UNION OF
ELECTRICAL, RADIO & MACHINE
WORKERS, IUE (AFL-CIO)

September 3, 1979
through
November 15, 1982

[UNION LABEL]

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SCHEDULE "D"

EMPLOYEE GROUP INSURANCE AND BENEFIT PLANS

The Company will maintain employee group insurance and benefit plans during the term of this Agreement of the following types: life insurance, accidental death and dismemberment insurance, non-occupational disability insurance, non-occupational basic medical insurance, non-occupational major medical insurance and dental assistance plan.

These employee group insurance and benefit plans will be administered solely by the Company. No matter concerning the foregoing or any difference arising thereunder, shall be subject to the grievance or arbitration procedures of this Agreement but rather shall be governed by the terms and conditions of the contracts issued by the Insurance Company to provide these coverages.

Effective September 3, 1979 the employee group insurance and benefit plan will be improved to provide the following:

* * * *

4) Out-patient mental and nervous coverage will be extended to covered dependents;

* * * *

EXHIBIT 18

MANDATED HEALTH INSURANCE COVERAGE— A STUDY OF REVIEW MECHANISMS

Report to the
Bureau of Insurance
State of Virginia

by

John G. Larson, Ph.D.

Department of Health Administration
School of Allied Health Professions
Medical College of Virginia
Virginia Commonwealth University

1979

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The author would like to acknowledge with gratitude the valuable assistance provided by officials with the following organizations:

Aetna Life and Casualty

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Blue Cross-Blue Shield of Colorado

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Blue Cross-Blue Shield of Virginia

Blue Cross of Maryland

Bureau of Insurance, State of Virginia

Commissioner of Insurance, State of Connecticut

Ford Motor Company

Health Insurance Association of America

Life of Virginia

Medical Society of Virginia

Reynolds Metals Company

Virginia Department of Commerce

Virginia Department of Health

Virginia Department of Mental Health and Mental Retardation

Virginia Hospital Association

INTRODUCTION

Purpose of Study

The Virginia General Assembly has been in the past and is presently being petitioned to mandate coverage for additional benefits and services of newly licensed health care practitioners. The problem is that such significant decisions are being made without any systematic assessment of the impact on the cost, quality of medical care, and the structure of the health care delivery system in Virginia. Virginia legislators lack the benefit of a critical evaluation of these important factors. The purpose of this study was to demonstrate the consequences of what generally appears to be insignificant decisions (regarding passage of mandated coverage) and to define criteria and an approach for evaluating the appropriateness of proposed mandated coverage legislation.

Scope and Approach

Specific proposals for mandated coverage by any groups in the state of Virginia or elsewhere were *not* evaluated. In no part of this study can the consultant be responsible for assessing the various legal issues nor any legal considerations which might be a part of a proposed mechanism or criteria.

An initial step in this study was to conduct a literature review with emphasis on general topics of mandated coverage and various related issues. Secondly, national organizations, such as the Health Insurance Association of America and the Association of Blue Cross-Blue Shield Plans, were contacted to gain benefit of their research and conclusions regarding the study topic. A third step was to interview various officials according to an interview guide focusing on trends in mandated coverage, problems with current review process, desirable changes in health insurance coverage, role of health insurance, alternative review mechanisms, considerations when re-

imbursing new practitioners, and activities in other states. Among those interviewed were officials with Blue Cross-Blue Shield, selected commercial insurance carriers, Virginia Department of Health, Virginia Department of Mental Health, provider groups, large employers, and others in and outside the state of Virginia.

The report is a synthesis of the current literature and input from the many parties interviewed.

Chapter I

TRENDS IN MANDATED COVERAGE

Nationally

Beginning in the Sixties there has been a trend throughout the nation for state legislatures to mandate various forms of additional health insurance coverage. Mandated coverage legislation requires all private insurance carriers to include in all accident and sickness policies sold in the respective state some form of additional benefit or coverage. The legislation may require that it be included as an option or required component. Generally speaking, the legislation is intended to increase the array of benefits or pay for practitioners' services which have formerly not been subject to the third party reimbursement.

Mandated coverage legislation throughout the United States requires private health insurance carriers (includes commercial insurers and Blue Cross and Blue Shield plans) to either provide or offer coverage for the following benefit categories:

1. Alcoholism and/or Drug Abuse
2. Catastrophic Coverage
3. Continued Coverage—Mandated Conversion
4. Dependent Coverage
    - Mentally and/or physically handicapped children

- Newborns
- Other, i.e., students, widows, spouses, etc.

5. Maternity Coverage
6. Mental and/or Nervous Conditions
7. Miscellaneous Benefits
8. Out-of-Hospital Care
9. Practitioners' Services

Treatment of alcoholism, drug abuse, and mental and/or nervous conditions represent empirically a very large part of the trend in mandated coverage legislation. Certainly, these are the more controversial categories of mandated coverage legislation. An employee benefits consultants' report shows that 20 different states have mandated coverage of alcoholism to some extent; 17 different states, mental and/or nervous conditions; and eight different states, drug abuse.[1] It must be recognized that approaches to mandated coverage vary from state to state. Since most of this legislation was enacted within the last five years, it is interesting to note that there has been a swing from legislation requiring provision of additional coverage to the lesser requirement that it be an option offered in all policies. Given the controversial nature of this legislation, legislators have no doubt found that optional coverage legislation is easier to pass and less likely to create an adverse reaction among their constitutents.

Statistically, catastrophic coverage is not a signfiicant trend; nevertheless, it is a recent initiative taken by a few states to address issues normally reserved for national strategists and their national health insurance proposals.

Dependent coverage is intended to address a problem of variability or lack of uniformity in benefits in policies which often appear to the public as similar. In many states, health insurance policies were being sold

that did not cover newborns, handicapped children, and so-called others, e.g., students, adopted children, and spouses. Newborn coverage has been mandated in many after reports that some insurance companies have denied coverage of newborn children with cogenital birth defects. It is a move to insure uniformity of coverage.

Some of the maternity coverage legislation is aimed at requiring that all complications of pregnancy be treated like sickness and injury under medical expense plans. The Pregnancy Disability Benefits Amendments to the Civil Rights Act (P.L. 95-555) recently signed into law requires that pregnancy-related medical conditions must be treated the same as other medical conditions under any health or disability insurance plan available in connection with employment.[2]

Out-of-hospital care category of mandated benefits includes payment for home health care services, outpatient surgical services, and a variety of other ambulatory services. The lack of reimbursement for purportedly less expensive ambulatory care services has been cited as a primary cause of the emphasis on acute care services and resultant inflation. This type of legislation is attractive to legislators given a concern over the rise in hospital care expenditures.

Practitioners' services legislation does not create any additional benefits for subscribers, but merely requires private insurers to reimburse additional practitioners (non-physicians) for services under present coverage, thus often characterized as "self-interest" legislation. This form of mandated coverage has increased since the Medicare program included various non-physician practitioners as eligible providers. These practitioners range from optometrists to clinical social workers.

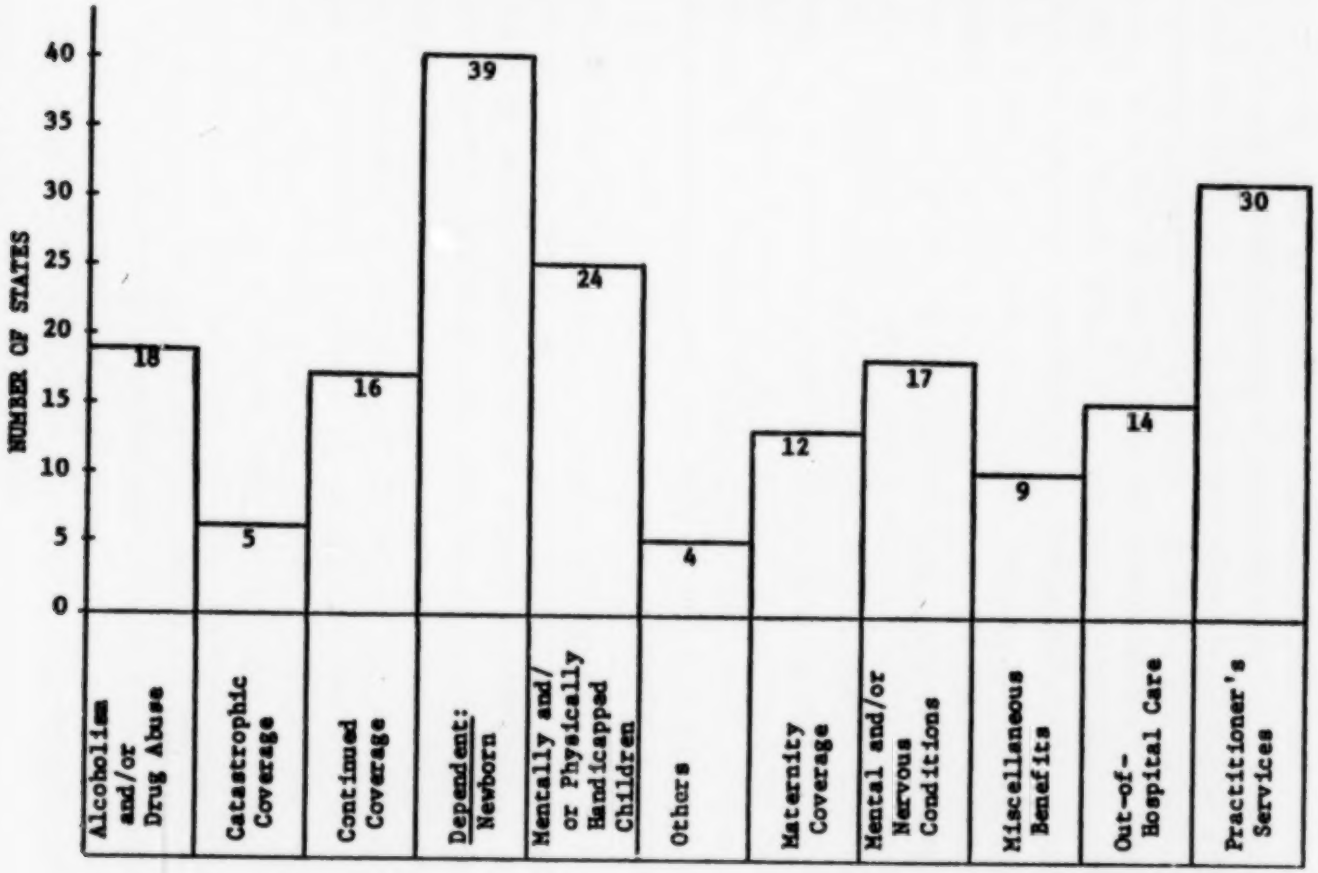
A tabulation of all mandated coverage legislation per state and year of passage can be found in Appendix A. Also, on the next page a chart illustrates mandated cover-

age legislation passed by a number of states. It does not include legislation much beyond 1977. Nevertheless, it demonstrates the trends throughout the nation.

Virginia

In Virginia, there was a rash of mandated coverage legislation starting in 1976. Coverage of newborns was mandated in 1976. During the same legislative session a law mandating coverage for mental disorders was passed. In 1977 this law was amended to require the offering of outpatient psychiatric benefits in all health insurance contracts. Concurrently, a mandated coverage bill was enacted requiring private health insurance carriers to offer coverage for inpatient and outpatient care for alcoholism and drug addiction under group and non-group family contracts.

DISTRIBUTION OF MANDATED COVERAGE BY NUMBER OF STATES - 1977



Source: Blue Cross-Blue Shield Association, State Required Health Care Benefits, 1978.

Future Trends

It is likely that a number of trends will emerge nationally. One is that there is likely to be an increasing number of mandated coverage bills passed which require additional coverage as an option. Secondly, the number of proposals to mandate practitioners' services will grow proportionally at a higher rate than other categories. Thirdly, the current interest in cost containment will generate renewed interest in mandating out-of-hospital care coverage, as reduced utilization of acute, inpatient services is a goal common to all cost containment strategies. Finally, social activist groups will attempt to use mandated benefit legislation as a means to indirectly influence public policy on controversial social and moral issues, such as abortion and women's rights.

These future trends are likely to be evident in Virginia, particularly practitioner services bills. During coming sessions of the General Assembly, the legislators may consider proposals to mandate coverage, or better said, payment of services rendered by a number of allied health practitioners, particularly in the mental health services field. The latter has been openly encouraged by the President's Commission on Mental Health. Proposals for mandating out-of-hospital care will remain evident; however, it is questionable whether they will achieve any significant political support. Accordingly, mandating uniform coverage of nursing home care, ambulatory surgery, home health services, or hospice care are likely proposals. These proposals demand close examination, since the change in reimbursement is not always apparent. Outpatient surgery is a good example. Many insurers already cover outpatient surgery by paying the surgeons' fees, but not the ancillary services. The interest behind the "surgi-centers" proposals in various state for mandating coverage of outpatient surgery is to achieve more comprehensive reimbursement arrangements beyond payment of surgeons' fees.

Chapter II

CONTRIBUTING FACTORS

The factors underlying the trend of mandating expanded health insurance coverage are numerous and identification varies according to the perspectives of each interested party—insurance executives, providers, and employers. Most are complex and will not receive a comprehensive explanation here, other than to demonstrate how each might be considered a causal factor. Factors identified during this study are listed below:

- Incomplete health insurance coverage
- Expanded definition of health
- Anti-physician sentiment
- Expanded number and types of practitioners
- Changing values and expectations of society
- Pressure to reduce taxpayers' burden
- Health insurance role as a change agent

Each will be addressed briefly in this chapter.

Incomplete Coverage

The trend is toward broad comprehensive coverage as reflected in the expansion into non-basic types of benefits and the growth of major medical coverage, which provides broad high-benefit-level coverage against many prescribed health care services. As comprehensive coverage contracts have become more prevalent, it has been adopted as the norm by which all coverage is judged. The point is that the perception of "gaps" varies according to the norm employed. How one defines the role of health insurance (to be discussed later) impacts on the definition of the norm. A more conservative approach may be to define the norm as a minimum benefit package.

Whatever the approach there are generally agreed upon unacceptable gaps in private health insurance coverage. One such example, which has resulted in a spate of mandated coverage laws throughout the nation was the lack of newborn coverage in policies sold in Virginia and most other states. Many young parents falsely assumed that they had such coverage and found out later when confronted with sizeable medical bills for the care of a sick newborn that this was not true at all. One might argue that this is a matter of personal responsibility; however, when purchasing health insurance, the average consumer is not an "informed buyer" and cannot be expected always to make a rational decision. Most consumers are not aware of what is adequate health insurance coverage, nor what existing policies provide. The definition of adequate coverage is dynamic and is a function of the life-saving potential of medical care and the attendant costs. Part of the reason behind the need for newborn coverage is the development of neonatal intensive care units. The recent improvements in the care of the sick newborn (e.g., premature infants) are impressive, but the costs are usually catastrophic.

Absence of newborn coverage for many families would be a source of substantial risk exposure. If the purpose of insurance is to alleviate the sizeable forms of personal financial risk, one might assume this should be a part of the basic health insurance package. A significant number of family health insurance policies with maternity benefits excluded newborn infants from the moment of birth up to 14 or even 30 days of life. The latter is the interval of highest risk; therefore, many insurers have avoided writing this form of coverage to minimize high-risk exposures. In some cases the newborn coverage was so ambiguously presented that families falsely assumed they possessed adequate coverage. The necessity for legislative intervention seemed apparent. This whole issue becomes more complex when reviewing the wide range of

opinions regarding the role of health insurance and the definition of health.

Expanded Definition of Health

As the capability of medical science expands, a corresponding re-definition or expansion of the concept of health has taken place. The World Health Organization Charter defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3] This seems to give the definition of perfect health no bounds, so it may be considered to be a feeling of ebullient well-being that causes one to burst into song with joy. This ideal state is only achievable for very brief periods. It is unrealistic and not likely to be achieved through the most sophisticated mental health programs. A way of defining health is to conceive of it as a range of possibilities. One extreme is death which is readily definable. Moving towards the other extreme through total disability, partial disability, and minor impairments towards perfect health does not establish a finite end point. Inevitably, perfect health is subject to individualistic interpretation and rarely achieved.

A more pragmatic approach is to deal with the subject in terms of poor health. This is a state of health so poor that it produces a need for treatment or impairment of productive function. Then, what is a need? If perfection is the goal, any condition for which a remedy is available constitutes a need for treatment. This is not much help. For practical purposes, a need for treatment should be defined as a physiological or mental condition which, in the light of current knowledge, the current resources of society, and the opinions of competent physicians, should receive treatment. Consequently, concepts of needs would be expected to change over time as does current knowledge and applied technology regarding the diagnosis and treatment of physiological and mental conditions. Before a need can be translated into action,

there must be a recognition of the need which may not seem problematic at first. The problem is that recognized need or consumer wants outstrips the present availability of resources. The concept of impairment of productive function is also somewhat vague. Productive function may be impaired by serious injury or disease or by chronic, relatively minor, ailments such as fatigue, constipation, indigestion, a dull headache, congested nasal passages and nervousness. By such a standard, most people's productive functions are impaired every day. There must be a practical criterion, thus the concept be restricted to impairment so severe as to cause a noticeable restriction of normal activity. Poor health may be defined as any physical or mental impairment which requires treatment in the opinion of an accepted medical practice or results in an observable restriction of normal activity. This certainly approaches more the "medical necessary" concept, which receives the strong endorsement of the insurance companies. The practitioner prefers a more fluid definition which preserves a sense of hope and faith in the endless possibilities of medical science; conversely, the insurers approach the subject with more economic pragmatism. This kind of conflict between goals and values in society today is the mother of government intervention. As shown earlier, much of the mandated coverage legislation is a result of expanding comprehensive coverage to include a wider range of mental health services. This is a predictable result of increasing acceptance that the health care delivery system bears some responsibility in insuring mental and social well-being.

Greater Expectations of Society

This may appear redundant, vis-a-vis the expanded definition of health section; however, the former section is a result predominantly of the professionals' or health care providers' changing definition of need. Society's ex-

pectations are certainly conditioned by the providers' choices or preferences regarding treatment modes. Nevertheless, changing societal values affect what is deemed a collective responsibility of society regarding individual risk that should be minimized through public and/or private insurance. Traditionally, alcoholism, drug abuse, and mental disorders were commonly viewed as instances of individual failure. It was considered a result of self-abuse and lack of control; therefore, the consequences should be a personal responsibility. Today, a more egalitarian philosophy has fostered the belief that society has responsibility for protecting such unfortunate individuals as well as society as a whole, since the negative impact is perceived to go beyond the domain of the unfortunate individual. Also, this may be a result of the growing magnitude of these health problems. Consequently, there is greater acceptance, even with the lack of strong consumer advocacy, of the inclusion of coverage for such problems in health insurance policies. A similar example is in the support of comprehensive coverage of maternity and newborn care. The belief is that a good outcome of pregnancy and post-natal care increases the chances for a good citizen, meaning a healthy and productive one.

Expanded Number and Types of Licensed Practitioners

Since the Sixties, there has been a proliferation of autonomous practitioners in the health care industry. Examples are clinical social workers, nurse practitioners, pastoral counselors, nurse midwives, alcoholism counselors, and so on. Many of the new allied health professions were spawned from theories to increase the access to health care services, lower cost, expand the productivity of physicians, and overcome shortages of selected health manpower, mainly physicians. For reasons of professional accountability and legal liability and the tradition that the physician remain the "gatekeeper" of the health care system. The physician controls entry into the system and provides the only pathway through the

system. Furthermore, the payment system has reinforced this arrangement. Given role expectations and tremendous variability in practice opportunities throughout the nation, these allied health professionals have been frustrated and rebellious towards the traditional medical model. Most believe that they cannot fully maximize their potential contribution according to their professional skills and knowledge. No doubt this dependency role has circumscribed what they would like to achieve economically and professionally. Consequently, these professional groups have been pushing for greater recognition as autonomous practitioners.

Today's society attributes the greatest prestige and status to the autonomous professional. The physician is the epitome of this. In pursuit of this standing in society, the new non-physician practitioners have sought licensure which entitles them to collect a fee for specific services. A natural question after this is why cannot he or she be reimbursed by the patient's insurance company? Few have been successful through petitioning insurance companies, so the next avenue has been to take the issue to the courtroom or the legislature to mandate payment. The insurance companies have resisted due to their concept of what is the role of health insurance and the need to maintain control through the "medically necessary" model.

Anti-Physician Sentiment

Some attribute the success of non-physician practitioner groups to gain passage of mandated payment legislation to anti-physician sentiment. This is not to give any credence to this, merely to recognize it as a force. Today, we have insurance companies paying medical specialists for professional services, even though they clearly recognize that in some instances almost one hundred percent of the service is being rendered by a non-physician practitioner. In theory the medical specialist is receiving a

fee for his clinical supervision. It is a problem when the physician does not appear to be exercising a proper degree of involvement. A common example cited by social workers in many states is an adult may meet with a psychiatrist to discuss apparent psychological problems. Treatment may be recommended; and, then the individual is turned over to a clinical social worker for therapy, and the psychiatrist may never involve himself in any visible way in the therapy program. A key word is visible, since the consumer does not see the psychiatrist being involved, so the conclusion is that the higher fee is inappropriate given the level of apparent professional input. The social worker may feel that he or she is not getting a just share of economic rewards, but more importantly the level of professional recognition is not commensurate with the level of input. As a result, we have social workers pushing for independence and individual reimbursement with consumers often backing them. This example does *not* represent the rule, yet such instances have fueled the antagonism.

Generally, the medical profession has not supported the mandated payment bills. The example cited earlier has led critics to say that physicians' opposition is derived out of economic self-interest. However, some evidence demonstrates that physicians' incomes are seldom affected due to infinite elasticity of demand. The same attack can be just as easily levelled at the proponents, but such comments skirt the legitimate, more prevalent concerns af all interested parties—i.e., costs and quality control.

Pressure to Reduce Taxpayers' Burden

As mentioned earlier, society's expectations and the expanding capabilities of medical science have created a need for more private and public health programs. In an era of "Proposition 13" there has been growing reluctance on the part of legislators to expand public programs to address problems, such as alcoholism, drug abuse, and

mental illness. Private sector programs in these areas have increased rapidly during the last decade.

It may be easier to mandate expanded private insurance coverage, rather than raise taxes to sponsor such programs. The belief is that the public sector is shifting such service responsibilities to the private sector as well as financial responsibilities, i.e., mandated coverage bills. It is deemed to be a form of "hidden taxation."

Health Insurance as Change Agent

The health care delivery system in this nation and the state of Virginia is beset with a number of problems. Frequently identified problems are rising costs, unnecessary utilization of expensive facilities and services, maldistribution of health manpower, and difficult access to primary care services for segments of the population. Often third party payment is the basis of a strategy for devising a scheme of incentives and disincentives to influence patterns of practice or allocation of resources. Put very simply, the technique is to make it economically advantageous for a physician, other practitioners, and consumers to utilize precious resources in a more prudent fashion.

Chapter III

IMPACT OF EXPANDED INSURANCE— CONCEPTUAL OVERVIEW

The focus of this study is to conclude on an improved approach to evaluation of mandated coverage proposals. A thorough evaluation must assess the probable impact of each mandated coverage proposal on premium costs, utilization levels, and total health care expenditures. This chapter presents an overview of what in the past has been the impact of expanding health insurance coverage.

One factor that conditions the estimation of impact is the evaluators' viewpoint regarding the role of health insurance. One extreme view may be that the health care system is essentially sound, and that the role of health insurance is to provide protection against unpredictable and significant financial risk. The other is that there really is a health care crisis and insurance should be used as an instrument to facilitate change, as well as provide income protection.

Regardless of the points of view it is more important, given the subject of this study, to understand the effects of expanded coverage. There are three. First, it usually lowers the out-of-pocket costs to the consumer for use of covered services. Secondly, when the out-of-pocket cost is lowered, the consumer has more cash to expend on non-covered health care services. Finally, it assures a flow of revenue to providers. This is usually greatest on a fee-for-service arrangement. The behavior of providers and clients is altered by these effects much as anyone would anticipate. The expected result are changes in the volume, content, and distribution of health services provided. This would be manifested in five ways, as follows:

1. Consumers use more covered services, and this also generates expansion of complementary services which the consumer is more able to afford.

2. A greater volume of services are utilized. Anyone who was not previously covered is more likely to use services if coverage is expanded to them. Also, the service is enriched through increased technological content and amenities.

3. The tendency is to increase and enrich those services covered by insurance and substitute those covered by services for those services that are not covered or only partially.

4. The use of non-life sustaining or less urgent services will increase since demand for these services is accelerated by lowering the out-of-pocket expense.

5. Also, there may be some increased use of preventive care services, if covered and out-of-pocket expense for these services more closely approach zero.[4]

In summary, expanded coverage will result in higher rates of utilization, an enriched health care product (i.e., greater use of expensive technology or more amenities), and some potential for redistribution of health care services or manpower to the otherwise deprived segments of the population. An important consideration in this age of scare resources is the trade-offs.

The trade-off can be assessed by the change in prices and total expenditures. A rise in prices is predictable since expanded coverage creates greater demand pressures on limited service capacity. Also, any changes in the health care product through improvements, whether new technology or amenities, will force the price of the covered services up. Total expenditures are increased by the dual upward movement of prices and volume. In the past, expanded insurance coverage has resulted in the provision of the more expensive services, rather than encourage the substitution of less expensive forms of treat-

ment when equally effective. The total subtle effect of expanded coverage is, as the increased prices and expenditures become a financial burden on consumers in the form of greater out-of-pocket expenditures and increased premiums, a renewed movement to expand coverage is generated. The need for expanded coverage has no limits; there are merely pauses. This does not mean the genuine social problems which spawn proposals for expanded coverage be ignored, rather that each decision be made in a very circumspect fashion. The immediate impact of any one decision usually appears to be minor; yet, as shown here, the long-term effects may be even more threatening to the very individuals that you are striving to help.

Another important point is that features of the health care system often limit the potential effectiveness of changes in health insurance in achieving certain objectives. Changes in health insurance are pursued for any number of reasons. Some objectives frequently identified by proponents of state mandated benefits will be discussed here to demonstrate what might be the more predictable consequences. These objectives are financial protection of individuals, improvement in the quality and quantity of health care services and reduction of costs through emphasis on out-of-hospital care.

No one would disagree that an objective of health insurance is to protect subscribers from the unpredictable costs of illness. Controversy arises over whether it is the only objective or simply the minimum purpose. There are two points to be addressed regarding income or financial protection. First, according to the classical definition of insurance it should be to protect individuals from unpredictable expense. Consumers want insurance that will protect their assets and style of living from all medical expenses. He would rather not make any further sacrifice than regular payment of a premium. The other point is that consumers expect the cost of protection (premium) to be at a reasonable level. The criterion for this is that

annual premium expense will not reach a level where the consumer must sacrifice the consumption of other goods and services. These two purposes inevitably conflict. As the level of insurance protection approaches absolute financial security, the cost of protection becomes exorbitant.

Judging the adequacy of protection provided by some form of insurance coverage is very difficult. It depends on how the health care services are consumed, in what order, how often, and the degree of medical necessity. A simpler approach is a measure of the consumers' liability. This may be done by setting a specified percentage of disposable income. The percentage figure may have to vary since our sense of equity may dictate that the poor should bear a smaller percentage of their disposable income.

Another important consideration is, as mentioned earlier, that increased coverage will encourage greater use of service and contribute to a rise in prices and total expenditures, particularly important an increase in health insurance premiums. In summary, great care has to be taken in pushing for increased protection as it creates a vicious cycle. Greater protection may result in increased expenditures which over the long run may result in the need for more protection. All the while premiums are increasing, thus demanding a progressively increasing share of the consumers' disposable income.

Improvement in the quality and quantity of health services is a frequently espoused objective for mandatory coverage. As stated earlier, a predictable consequence of expanded coverage is increased usage and an enriched product. This does not necessarily mean people will receive better care. Simply paying more for the same services without attention to the process will result in diminishing returns to scale. Contemporary thinking is focusing on the fact that consumption of health care

services does not result in better health. In fact, there is some possible loss due to iatrogenic disease and dimunition of resources devoted to improving our standards of living.

A frequent argument for modifying coverage is to pay for more out-of-hospital care, e.g., outpatient surgery and home health services, thus reducing costs. Regrettably, experience has shown the latter not to be true. Expanded coverage has resulted in much greater consumption of the newly covered service and rapid expansion in capacity of these services without a corresponding reduction in hospital usage. Total costs go up! It appears that in some cases hospital usage increased. Appropriate controls must accompany the expanded coverage to reduce hospital usage and capacity, thus costs may decrease or at least stabilize.

Another objective may be to achieve a better allocation of resources among the types of health care services. To be economically sound the allocation of resources to less serious or vital services must be shown to *genuinely* contribute to the prevention of illness or its early detection and arrest.

Finally, a common objective of mandating payment of practitioner services is a more equitable distribution of services and manpower. The belief is that improved purchasing power created by expanded coverage will attract practitioners to underserved areas. The opposing view is that physicians and other practitioners are attracted to locations which are desirable due to cultural opportunities, favorable climate, opportunities for professional interaction, and recreational opportunities. Practitioners cannot always go to the more desirable areas, since there is usually an oversupply and it is difficult to make a reasonable living. The real contradiction is that mandated payment, thereby generating greater purchasing power in the already oversupplied areas, will make it financially feasible for practitioners to move into

the attractive areas. Obviously, the underserved areas will not enjoy the proposed benefit. The effects of the Medicare and Medicaid programs have demonstrated this point.

Evaluation of mandated coverage legislation must take into account the probable consequences vis-a-vis the targeted objectives. The health insurance mechanism has clear limits as an instrument for remedying many of the very real problems with the health care delivery system in Virginia. Expanding coverage by legislative mandate has very serious potential for increasing the cost of insurance, raising total health care expenditures, generating unnecessary utilization, and exacerbating the maldistribution of health manpower. These effects are long-term and are much greater than the apparent immediate consequences of a small premium increase. This is why an indepth analysis of each mandated coverage proposal is necessary. Mentioning these possible negative effects is not intended to preclude further consideration of mandated benefit proposals. Rather legislators and bill proponents must anticipate such consequences.

Chapter IV

ISSUES

The purpose of this study has been to investigate whether there may be a better way of deciding on the appropriateness for state mandated coverage legislation. The decision is and should remain the responsibility of the Virginia General Assembly. Therefore, the emphasis must be on how we can improve on the quality of each decision. The previous chapters intended to lay a foundation for understanding the general trends and the impact of changes in health insurance coverage on the health care delivery system. This chapter focuses on what is problematic with the current process of reviewing legislative proposals for mandated coverage. An important aim of this chapter is to further identify deficiencies or limits in the current process, both existing and anticipated, that should be addressed in any alternatives purported to be improvements.

Problem With Current Decision-Making Process

Proposed mandated coverage bills are discussed in the appropriate House and Senate legislative committees, then voted upon in each House of the Virginia General Assembly.

One prominent concern regarding the current process is the limited amount of time devoted to a proper review in each of the legislative committees. For this reason and others there is no indepth, comprehensive evaluation of each proposed bill. The Virginia General Assembly is under extreme pressure to effectively handle the massive amounts of work they must perform each session. Mandated coverage legislation is a relatively insignificant item compared to many other more significant issues and proposed bills. Each legislative committee must apportion its time among a multitude of bills, and

predictably the more important ones are judged by degree of impact on tax revenue dollars. It appears that most of the mandated coverage bills have been successfully passed; therefore, one might expect that any evaluation mechanism would be viewed by bill proponents as an obstruction and unnecessary bureaucratic interference.

Another aspect which is partially a result of time limitations is the failure to examine the proposals according to critical questions or uniform criteria regarding cost impact, change in the distribution of services, effect on quality of care, probability of achieving proposed objectives, and so on. The debates are too often emotionally charged and one-sided given the limited input. In such an atmosphere, bill proponents are at an advantage because it is usually a one shot effort and this makes it easier to exaggerate claims and downplay pragmatic considerations, such as costs. The opponents are usually raising questions which are difficult to answer and seem to oppose postulated outcomes which are undeniably desirable, yet may be unattainable given current resources and potential costs.

Input is usually limited to proponents and insurance company lobbyists. Occasionally, medical society lobbyists enter the discussions usually depending on the nature of the proposal. Legislative committees do permit input from any interested parties, such as consumers and health planners; however, they appear to lack the awareness of the need to inject themselves into the discussions. The health planning agencies can be a valuable source of input. Often, a purpose of the proposed legislation is to remedy access and resource distribution problems. Staff of a local or state health planning agency should be able to define the extent of the problem and what is the likelihood of achieving the expected outcome. A broader range of input is desirable and necessary.

The advantage of more time and expanded input is that the long-term consequences of such decisions will be more

clearly judged. The immediate impact on premium rates is usually small and seemingly insignificant; yet, as explained in the previous chapter, the long-term consequences are usually higher prices and increased utilization. This may cause a rise in total expenditures and eventually a rise in insurance premiums. The net gain to the consumers over the long run may be then questionable. This does not mean all proposed bills should be squelched, merely that when passage of a mandated coverage bill is desirable, concurrently controls or structural changes in the system should be implemented to minimize the deleterious effects.

The process of review of proposed bills in the future must facilitate more forms of input; dedicate more time to the review process; and evaluate the proposals according to clearly defined criteria. A universal concern of most persons interviewed during the study was the prospects of increased regulation and interference by introducing such a review mechanism. On the other hand, an often expressed viewpoint is that eradication of the current non-systematic, chaotic process is worth the risk.

Interference With Free Market Forces

One objection to mandated coverage legislation is the interference with individual freedom. The belief is that the decision regarding the choice of benefits should rest with the consumer. In a competitive, free market system, the consumer has the opportunity and ability to be well informed and is able to bargain among producers to obtain the best terms of sale. In the market for health care services and insurance coverage, the consumer is not well informed, particularly as to the consequences of inaction or alternative actions. For this reason, some consideration might be given to mandating a minimum benefit package and then leave all additional coverage completely to individual selection. The National Association

of Insurance Commissioners has prepared model regulations for minimum benefits standards.

The difficulty is to define what minimum benefit package is needed. The variation in approach will depend on the perceived purpose of insurance coverage and provider's interests. One example of the complexity is maternity coverage. The elderly and single males could argue that a minimum benefit package should not include such coverage as they are being discriminated against by bearing this share of risk. However, it is in the interests of society for all mothers and children to receive proper care. To keep premiums for maternity care at a reasonable level, then the risk must be spread over a pool of persons larger than the group most likely to need or use maternity services. Otherwise, some degree of adverse selection would occur. Couples having achieved the desired family size would choose to drop such coverage.

Consumers strive for the most comprehensive protection and want to sacrifice as little resources as possible. These are always conflicting goals when searching for a definition of adequate coverage. Many insurers would welcome a mandated minimum benefit package, since it would eliminate competitors marketing "inferior" policies, such as "dread disease" policies or ten dollar-a-day hospitalization plans. The state of New York has enacted legislation prohibiting the sale of "dread disease" policies.

The insurers commonly argue against the state mandating benefits because the process of negotiation between labor unions and employers is an adequate reflection of consumer preferences and needs. There is a clear bias, since insurance companies prefer group health insurance business, and it is usually their point of reference in discussions on this matter. The Virginia General Assembly is concerned with all Virginians; and union-employer negotiations only covers approximately 247,000 workers (13.8% of employed persons in Virginia in 1974).[5]

Group hospitalization plans are sold to many more persons through non-unionized employers all over Virginia. It would be naive to assume that employee interests are the paramount concern in the selection of an employee health insurance plan. This in no way implies irresponsibility, merely that a critical criteria is premium cost. Smaller firms (as measured by number of employees) generally lack the motivation and the staff support to evaluate benefit packages versus employee needs. Unions do this simply because they possess the proper resources. Part of the insurer's concern is that mandated coverage may exceed what is demanded by non-unionized employers, and they will not be able to successfully market their plans.

State mandated benefits create problems for large, multi-state employers. These firms have plants or outlets in a variety of states with differing mandated benefits. Administration of separate benefit packages is a problem since it increases the expense and increases the inequity of benefits among employees. The result is that many such firms have opted for self-insurance due to proven cost savings. The regulatory mechanisms of Virginia have no authority over self-insured companies; consequently, the intent of mandated benefits is circumscribed. The insurance companies are concerned since this is a loss of business; though, the commercials and the Blues still have an opportunity to market their services of claims processing, reinsurance, or general administrative support to the self-insured. One tactic by these larger companies has been to fight for exemption from state mandated benefits under provisions in the ERISA legislation. Standard Oil has filed suit to gain such an exemption.[6] The federal government—largest, multi-state employer—has gained an exemption under the recently enacted Preemption Bill (HR 2931). This federal law (P.L. 95-368) preempts Federal Employees Health Benefits carriers from providing state mandated benefits

or making payments for services performed by state mandated providers if the Federal Employees Program contract does not otherwise allow benefits for these services or providers.[7] This will limit the provision of state mandated benefits in northern Virginia and other areas of Virginia with sizeable concentrations of federal employees.

Control Over Cost Escalation

Expenditures on health care have risen dramatically. These increases reflect a combination of forces: increases in price, population growth, increased utilization of medical services, and quality improvements. State mandated benefits are of some importance regarding this issue. Demand for services is a function of both supply of services and insurance coverage. The President's Council on Wage and Price Stability Staff Report (January, 1977), addressed this very point in their findings, as follows:

> "Patients demand (and hospitals supply) increasingly and use sophisticated hospital services because public and private insurance pays a growing share of the cost of care." [8]

As conceptualized in Chapter II, expansion of insurance coverage is cost-raising. Accordingly, further expansion of mandated benefits may result in discontinuance of coverage by small employers due to increased cost. If it is appropriate to expand coverage, then we must make provisions that will create some trade-off in the use of resources. The possibilities are unlimited. A simple example is a requirement that when adding an ambulatory care service to the benefit package, a financial incentive or controls be created which will limit use of interchangeable inpatient services. Interchangeable connotes substitution of an ambulatory service when it is cost effective and equally efficacious. For example, dilation and curretage performed on an inpatient basis

will not longer be covered, unless the medical necessity for hospitalization is documented.

Another example might be to stop paying psychiatrists for services which can be performed by clinical social workers; or, only pay clinical social workers located in "physician shortage" areas. In addition, control can be exercised by limiting social workers' fees to some propor tion of psychiatrists' fees, possibly one-half.

To continue expanding health insurance coverage/ benefits without controls or offsetting reductions in other benefits will only further inflate health care costs.

Measuring Cost Impact

The impact of mandated benefits on premium costs and overall health care expenditures is routinely raised as a point of contention. This is a very appropriate consideration as previously stated. Yet, the argument seems to lack any real effect on the decision-making thus far.

The reason may be, as shown on the following page, that the addition to the monthly premium expense appears to be small. For instance, the estimated impact on the rates of a midwestern Blue Cross-Blue Shield plan for covering chiropractor services is $0.26 per month for a single policyholder and $0.66 per month for family (group rates). However, multiply this figure times the number of subscribers and the amount of money becomes significant. If this were to be done with crude estimates, there could be an initial cost to Blue Cross-Blue Shield subscribers in Virginia of $11,000,000 annually which will be borne by individual consumers or employers. The reader must be aware that these are only crude estimates, using cost figures from another state which may understate or overstate the cost to Blue-Shield subscribers in Virginia and does not include cost of coverage provided by commercial insurers.

SCHEDULE OF BC/BS GROUP RATE CHANGES DUE TO STATE MANDATED COVERAGE IN MID-WESTERN STATE

Type of Mandated Coverage	Additional Monthly Premium Expense	
	Single	Family
Chiropractor Services	$0.26	$0.66
Basic Dental Services	.13	.30
Optometrists	.01	.03
Podiatrists	.11	.27
Newborn—Ill Baby Care	—	.67
Psychologists—30 days of Inpatient Care	.29	.72
Psychologist Services Only	.01	.04
Increase Outpatient Visits from 30 to 45 Under Blue Shield	.49	1.22
Nervous, Mental, Chronic Alcoholism, and Drug Addiction Under Blue Shield Major Medical	1.60	3.52
Increase Inpatient Days from 30 to 40—Nervous, Mental, Chronic Alcoholism, and Drug Addiction Under Blue Cross	.09	.18
Chronic Alcoholism and Drug Addiction—Blue Shield	.04	.10
*Catastrophic Coverage	3.68	9.20
Physical Therapists—Outpatient	.30	.74
Physical Therapists—Inpatient	.05	.12
Well Baby Care	—	.26
Obstetrical Benefits on Single Contracts	.59	—

Source: A mid-western Blue Cross/Blue Shield Association (Annonymous per request)

*Percent of covered benefits in excess of $5,000 per individual, or $7,500 per family per contract period of 12 months with a three month carryover provision. Mental illness benefits covered up to 50% for inpatient. Outpatient visits up to 20 visits during a 12 month benefit period.

In Maryland the Economic Matters Committee of the State Legislature with the assistance of the Maryland Blue Cross and Blue Shield Plan studied the cost impact of eighteen health insurance benefits mandated over the past ten years. After reviewing this data, the Committee concluded (Appendix C):

> "It appears from the data in the Blue Cross-Blue Shield Report that the mandated coverages passed by the Legislature in the last decade may have increased the cost of health care to the health insurance policyholder without necessarily improving the quality of where a health service is added as a benefit paid by insurance, the incidence of the unnecessary utilization of that service may increase. The Committee questions the ability of the average policyholder to afford these mandated coverages when one considers that there is doubt as to whether his health care has been improved." [9]

The Maryland Blue Cross Plan calculated that the eighteen benefits increased Blue Cross subscribers' premium costs by approximately $23.5 million per year. An additional $12.5 million in premium cost would be incurred by subscribers if they elected to purchase mandated optional coverage. The effect on Blue Shield aggregate premium cost would be approximately $3 million per year (Appendix C).

The impact of mandated benefits on premium expense is more extensive than appears by the immediate net change in monthly premium expense. More importantly, the purported benefits have to be seriously considered in light of the full impact on health care expenditures.

Most of the cost of group health insurance programs (the predominant form of health insurance sold) is borne by employers. The net effect of expanding insurance coverage is to inflate the costs of doing business in Virginia.

The aforementioned are the more apparent costs. Total expenditures will be raised by increased coverage, due to predictable increasse in utilization of covered and non-covered services, some of which may be inappropriate. In the case of coverage for institutional services an expansion in capacity is likely. The capital expenditures may become significant; this is a critical factor in rising health care costs. All are long-term effects which again necessitate careful examination.

Many states have embarked on programs of deinstitutionalization of the mentally ill with emphasis on the private sector to serve their needs. Accordingly, insurance coverage and private psychiatric services have been expanded. Yet, public officials and private citizens are now questioning the efficacy and cost-effectiveness of this policy. Should mandated insurance coverage be used as a means for effecting State policy goals? At the risk of sounding redundant, it must be appreciated that changes in coverage are more far-reaching than the immediate increase in premium expense.

New Practitioners

As the concept of comprehensive health services has taken hold, there has been concommitant acceptance of the role of non-physician professionals in providing health care services. These various professionals—chiropractors, nurse midwives, nurse practitioners, psychologists, clinical social workers, physicians' assistants, and so on—have sought professional recognition through licensure and then reimbursement as an independent practitioner. Mandated coverage legislation will normally read that the practitioner can perform within their scope of licensure and is entitled to reimbursement for rendering such services by the commercial and prepayment insurance companies. In most cases, the scope of practice has no limits other than the non-physician practitioner cannot admit patients to a hospital and prescribe drugs.

The source of controversy is that insurance carriers have declined to reimburse non-physician practitioners directly as a bona-fide independent provider. Yet, the clinical social workers, psychologists, nurse practitioners, and others enjoy third-party reimbursement if they provide their services within a physician's practice. Few insurance carriers have established procedures for looking beyond a physician's claim for reimbursement as to whether the physician or non-physician practitioner provided the particular service. There is variation in procedure all over the nation. The most important feature to the insurers is that under no circumstances should a non-physician practitioner be reimbursed for a service unless it is under the supervision of a physician. The practitioners will argue that their contribution cannot be maximized until payment is made directly to them without the service being ordered or supervised by a physician. Proponents of mandated payment bills have argued for removal of this restriction on their practice with claims of improved distribution of health manpower and reduced costs.

The stated claims are worth pursuing as long as there is some certain likelihood of success. The doubt is derived from practical experience. In the past when consumers have been granted greater purchasing power, there has been little redistribution of health manpower and no dimunition in health care costs. These problems will not be remedied by free market forces, so at the least mandated payment bills have to be designed differently in the future to increase the probability of success.

The findings of researchers and insurance executives might be summarized in the following cautionary notes regarding expanded coverage of new practitioner services:

1. Practitioners are not drawn to underserved (manpower) areas, in fact find it possible to practice in over-supplied areas due to the expanded purchasing power.

2. Due to the broad scope of licensing laws, expanded coverage often allows unqualified practitioners to enter the marketplace as providers.
3. Third-party reimbursement of new practitioners on a fee-for-service basis will inflate expenditures. Fees of the non-physician will escalate over a short period using physicians as the frame of reference.
4. The availability of third-party payments will lure practitioners from the public sector into private practice. The effect may be that the "less needy" and more affluent consume a greater proportion of resources.
5. Treatment strategies will be determined more by economic considerations than by clinical principles.

Regarding item #3, Blue Cross and Blue Shield of Colorado has found in offering a new benefit which allows direct payment to psychiatric social workers that their fees have started to approach the level of psychiatrists' fees ($55.00 to $60.00 per hour).[10] These are preliminary findings. The possible undesirable effects, listed above, of mandating payment of independent, non-physician practitioners are particularly likely when initiated without limits or controls.

The federal government may have set forth an example in recent regulations under the Rural Health Clinic Services Act of 1977 (P.L. 95-210).[11] The regulations permit reimbursement for services provided by physician assistants or nurse practitioners in rural health clinics on a cost basis, not fee-for-service. Eligible sites must be located in areas underserved by physicians, as determined by the Secretary of H.E.W. Another important feature is these providers need only to have services reviewed by a physician and a physician must be routinely

available for consultation. This is a loosening of the stricter "medically necessary" model.

There are ways to assure some minimum level of quality and proficiency. One method is to tie eligibility for reimbursement to specific educational qualifications or professional certification. To facilitate this the respective professional association could develop a "directory" of qualified practitioners. Eligibility could be conditioned upon participation in an approved peer-review activity. The focus would be the appropriateness and quality of services provided.

The purpose of reviewing each of these critical issues in this chapter is to highlight the important components of the need for uniform criteria in evaluating the appropriateness of mandating additional benefits. The criteria will serve to guide an analysis regarding the likelihood of achieving the objectives stated by a bill's proponents. Also, it will sensitize those responsible for evaluation to the possible need for limits or controls. If mandated coverage legislation is expected to reach beyond the providers' interests, then every effort must be made to insure improvement of the consumers' status.

Chapter V

ALTERNATIVE REVIEW MECHANISM

There are seven alternative mechanisms to the present process of evaluating mandated coverage bills in the Virginia General Assembly that have been identified during the course of this study. Continuing with the status quo is always an alternative until it can be excluded once one of the other alternatives is believed to address the identified problems.

Summary of Problems

To set the perspective for evaluation of each alternative mechanism, the problems with the current process have been summarized below:

1. Proper amount of time is not allocated for review of proposals in the rush of the legislative session.
2. Undue pressure by special interest groups appears to preclude comprehensive, indepth analysis of all pertinent issues.
3. There is a lack of uniform criteria by which each proposal is evaluated.
4. Current review process does not facilitate wider number of input types with expertise in health planning, licensure, utilization review, and cost containment methods.

An implication of all four statements is that given the complex nature and varied consequences of each decision to mandate coverage, a different approach must be seriously considered.

Guiding Principles of Organization

Only the imagination limits the number of potential alternatives. Yet, no alternative mechanism is accept-

able at any cost, merely because it addressed the four identified problems. For this reason the consultant developed five guiding principles of organization, listed below, which served as a basis for disqualifying some potential alternatives and constructing others:

1. Expansion of state government must be minimized, thus cost to taxpayer.
2. Review mechanism must not intrude on decision-making autonomy of Virginia General Assembly.
3. Placement of review mechanism within government hierarchy and membership must be predicated on avoidance of dominance by any one interest group.
4. Technical assistance in the areas of insurance and health care delivery must be available to membership of any body reviewing proposed mandated benefit legislation.
5. A more effective review process will require clearly defined and stated operating guidelines, mission statement, and evaluation criteria.

Alternatives

The eight alternatives are reviewed uniformly regarding elements, such as structure, membership, scope/function, review process, source of staff assistance, and then the advantages and disadvantages are discussed. In Appendix B, each of the alternatives are exhibited in an abbreviated fashion to facilitate easier comparison. Each element is only addressed insofar as it might deal with review of mandated coverage bills.

Alternative #1—Status Quo

Structure	—Legislative Committees in the two Houses of the Virginia General Assembly are the site of mandated coverage bill review.
Membership	—Legislators and consumers.

Scope of Activities —Reviews all proposed bills.

Review Process —Once mandated coverage bill is drafted, bill is referred from Desk of Clerk of House of Delegates to the appropriate legislative committee.

Source of Technical Assistance —Joint Legislative Audit and Review Commission and other State Agency Staff can always be called upon.

Discussion —The deficiencies of the current process have been discussed throughout this report. There should be no change in the status quo unless one of the other seven alternatives offer a demonstrable improvement.

Alternative #2—Review by State Health Coordinating Council (S.H.C.C.)

Structure —S.H.C.C. is located in the Virginia Department of Health.

Membeship —This is dictated by Federal Health Planning legislation (P.L. 93-641) as follows:

> ". . . no fewer than sixteen representatives appointed by the Governor of the State submitted to the Governor by each of the health systems agencies; each such health systems agency shall be entitled to at least representatives on the S.H.C.C.; not less than one-half shall be individuals who are consumers of health; the Governor of the State may appoint such persons (e.g., public officials and providers) . . . may not exceed forty percent of the total membership." [12]

Scope/Function —Upon request of Virginia General Assembly, S.H.C.C. would review and comment on impact of mandated benefit bill.

Review Process —The bill would be referred by Chairman of House Legislative Committee to S.H.C.C. for review. Public hearings conducted; staff of State Health Planning and Development Agency performs impact study; and full S.H.C.C. reviews findings and submits comments and/or recommendations to House Committee.

Source of Staff Support—Division of Health Planning and Resource Development provides Staff and administrative services to S.H.C.C.

Discussion —Advantages are this is already existing agency, which possesses data and has health planning expertise, and should have developed insights into health care needs in Virginia. Disadvantages are the S.H.C.C. has already a heavy workload and faces an inordinate number of complex issues. Alloting a proper time to review mandated coverage bills would be difficult. The entire health planning effort has not been entirely successful, and its future is not predictable.

Alternative #3—Bureau of Insurance Advisory Commission

Structure —The Advisory Commission would be located in the Bureau of Insurance. Members would be appointed by the Governor. There would be no compensation, but members would be reimbursed for appropriate expenses. Terms of appointment would be for three years; however, of the initial members, two would be appointed for a term of one year each and three for a term of two years each.

Membership —Eight members appointed by the Governor and three ex-officio members:

2—Consumers (one from a labor union).
2—Legislators (one from each House).
1—Chairman, Statewide Health Coordinating Council or designee.
1—Chairman of a Professional Standards Review Organization in Virginia (a physician).
1—Member from Board of Commerce (preferably member on subcommittee dealing with study of licensure needs).
3—Ex-officio, Commissioner of Insurance, Commissioner of Health and Commissioner of Mental Health.

Scope of Activities —This commission would be responsible for review and comment on *all* mandated cov-

erage bills and conduct under its own initiative analysis of health insurance coverage, impact on costs, and so on.

Review Process —Steps would be as folows:

(1) All bills must be referred by Chairman of Legislative Committees or proposals may be submitted by Insurance Commissioner who may be petitioned to do so by general public or professional groups.
(2) Public hearings.
(3) Bureau of Insurance staff conduct study.
(4) Advisory Commission deliberate on public hearings results and findings on staff.
(5) Vote on formal recommendation.

Source of Staff Support—Staff of Bureau of Insurance, Department of Health, and Department of Mental Health.

Discussion —Advantages are minimal expansion of government bureaucracy and cost is minimized; Bureau of Insurance appears to be most neutral body and best able to develop the technical expertise; this alternative provides flexibility in composing membership of advisory commission; the decisions are primarily dealing with insurance matters; and this alternative is likely to have the most support.

Disadvantages are some groups may believe Bureau of Insurance is too close to some of the concerned parties. Often, it is believed a regulator is captured by the "regulated." This is not to criticize existing staff, only recognizes this analysis must transcend consideration of current personalities.

There are a couple of controversial features of the suggested review process. It should be required that all bills are referred to the Advisory Commission for a recommendation; otherwise, a referral if optional, is likely to be perceived to be a step to kill it. Consistency will lessen this perception. Before proposals directly sub-

mitted by the general public or professional groups can be reviewed, the Insurance Commissioner must approve after being petitioned; or the Chairman of the Advisory Commission may reserve this authority.

Alternative #4—Virginia Health Care Cost Containment Commission

Structure —Stands as an independent commission created by a Joint Resolution of the Virginia General Assembly with a short life of two years.

Membership —Appointed by Governor:

Consumers
Legislators
Ex-officio, Commissioner of Health, Insurance Commissioner, and Commissioner of Mental Health

Scope of Activities —Commission would be responsible for review and comment of all mandated coverage bills and under existing "investigative powers" could study health insurance problems.

Review Process —Same as Alternative #3.

Source of Staff Support—Staff from Bureau of Insurance, Department of Health, and Department of Mental Health.

Discussion —Advantages are already existing body with mandate to study respective issues; mix of legislators and consumers in membership is believed to be desirable; and is viewed as neutral body.

Disadvantages are the short life of the commission; limited scope of activities may not justify expense of free-standing commission; and additions to membership is precluded by Joint Resolution.

Alternative #5—Virginia Health Services Cost Review Commission

Structure —Recently established by Virginia legislation as free-standing body.

Membership —Prescribed by law to be appointed by Governor, as follows:

3—Consumers
3—Health Care Administrators
1—Blue Cross/Blue Shield Representative
1—Commercial Insurance Representative
Ex-officio members, Commissioner of Health, Commissioner of Mental Health, and Insurance Commissioner.

Scope of Activities —Empowered to review hospital charges on a voluntary submission basis and provided investigative powers.

Review Process —Same as Alternative #3.

Source of Staff Support—This body is entitled to own staff, so can hire appropriate technical staff.

Discussion —Advantages are the Commission will eventually be involved in investigating hospital costs. Members on the Commission should develop valuable insights and abilities.

Disadvantages are the mandated responsibility is so complex and time-consuming that there will be little time for additional duties. Activities will be limited essentially to hospital costs.

Alternative #6—Advisory Commission Within Office of Secretary—Human Resources

Sturcture —Located in executive branch, yet serves in advisory capacity to Virginia General Assembly.

Membership —Same as Alternative #3.

Scope of Activities —Review all bills and proposals; and initiate research and evaluation studies.

Review Process —Same as Alternative #3.

Source of Technical Assistance —Staff from one of departments grouped under Human Resources (e.g., Department of Health—Division of Health Planning).

Discussion —One advantage is this one may be the most neutral site short of creating a new independent commission. However, a disadvantage is that another branch of state government, formerly not involved, will be

brought into the deliberations. Also, the Secretary's Office lacks the technical assistance support necessary within the Office's immediate staff.

Alternative #7—One Year Study Commission—Minimum Benefit Package

Structure —Free standing, located in legislative branch; similar arrangement to Virginia Health Care Containment Commission or could be a subcommittee of latter.

Membership —Nine appointees by the Governor:

2—Consumers (1 member of labor union).
1—Blue Cross/Blue Shield Representative.
1—Commercial Insurance Representative.
1—Non-Governmental Health Care Administrator.
1—Chairman, State Health Coordinating Council.
1—Legislator.
1—Chairman, Professional Standards Review Organization.

Scope of Activities —Evaluate health insurance coverage needs and identify gaps in existing coverage, preferably with a temporary moratorium on mandating any additional benefits and coverage.

Review Process —Proper study would consist of public hearings on selected subjects and staff reports, then, if appropriate, legislation would be recommended.

Source of Staff Support—State agency personal, J.L.A.R.C., and/or consultants.

Discussion —Mandated coverage proposals are at times a result of clear problems in proper coverage, rather than just the interests of providers. Proper study of the needs may address the real problems of consumers, and a minimum benefit package may lessen the stream of mandated coverage proposals to the General Assembly. This issue is currently on the agenda of the Virginia Health Care Cost Containment Review Commission. Yet, this issue deserves a higher priority; and, if it is not properly

addressed by the Cost Containment Commission, then a new group should be organized. The main disadvantage is the expense of organizing another commission.

Alternative #8—Free Standing, Mandated Coverage Review Body

Structure —It would be located in the legislative branch, yet independent to perform designated duties. The link with the Executive branch would be through appointments by the Governor.

Membership —Appointments by the Governor would be:

3—Consumers (one from a labor union and a large employer).
2—Legislators (one from each House).
1—Chairman, Statewide Health Coordinating Council or designee.
1—Chairman, a Professional Standards Review Organization in Virginia (a physician).
1—Member from Board of Commerce (preferably member on subcommittee dealing with study of licensure needs).
3—Ex-officio, Commissioner of Health, Commissioner of Mental Health, and Insurance Commissioner.

Scope of Activities —Review mandated coverage proposals and recommend action to General Assembly; initiate research and evaluation studies into related areas.

Review Process —Steps would be as follows:

(1) All bills to be referred by Chairman of Legislative Committee or proposals submitted by Insurance Commissioner who may be petitioned to do so by general public or professional groups.
(2) Conduct public hearings.
(3) Bureau of Insurance staff perform study.
(4) Advisory Commission deliberate on public hearings' results and staff analysis.
(5) Commission vote on formal recommendations to General Assembly.

Source of Technical Assistance	—Hire own staff.
Discussion	—The advantage of this alternative is that it would be a truly neutral body. However, for the limited scope of duties, it may seem to be an unnecessary additional commission and expense to the taxpayers.

Evaluation Criteria

Whatever the preferred alternative, there must be uniform evaluation criteria applied to each mandated benefit proposal. If one of the seven alternatives to the present process is adopted, an absolutely critical component of the implementation phase is adoption of criteria by the membership of the review body. Even if the status quo is the preferable alternative, a Chairman of a legislative committee can use the suggested criteria in guiding the discussion and review of mandated coverage bills.

The suggested criteria is presented below. Questions are listed beneath each criteria to illustrate what specifically must be analyzed in order to perform a thorough evaluation.

Unmet Need—Whether it be a mandated coverage or payment of new practitioners' services, the rationale usually is that a segment of the population does not have necessary access to medical care or suffers an unnecessary financial hardship in the purchase of such services.

1. Current geographical distribution of pertinent providers/health manpower?
2. What are other alternatives to meeting the identified need?
3. What are the findings of the State Health Planning Agency and the appropriate Health Systems Agencies?
4. How will it contribute to the quality of patient care and the health status of the populace?

5. Is this a medical or a broader social need and does it fit in with the role of health insurance?
6. Is proposed mandated benefit legislation advocated by providers or consumers? What is the consumers' attitude regarding the need for this legislation?
7. How is the service being paid for now, does it limit private health insurance subscribers' ability to gain access to needed health service, exclusive of recipients of public service programs?
8. What evidence and/or experience in other states is there to demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?

Cost Impact—This must be analyzed in terms of additional premium expense to consumers and the impact on total health care expenditures.

1. What is the projected utilization of the service to be covered by the mandated benefit over the next five years?
2. What are the anticipated fees/rates for the next five years and how do they compare with alternative providers?
3. What is the estimated increase in insurance premiums over the next three to five years?
4. What is the probable magnitude of the impact on total health care expenditures?

Control Over Utilization and Costs/Fees—Given the already excessive inflation in cost of medical care, changes in coverage or payment of new practitioners must be accompanied by measures to minimize unnecessary utilization and excessive growth in costs. This chiefly pertains to payment of new practitioners.

1. How will non-physicians be reimbursed fee-for-service or costs, and which one minimizes cost?
2. How will reimbursement be negotiated?
3. What are the bases of determining eligibility for payment?
4. Document how utilization review will be performed and ways to monitor effectiveness?
5. Should reimbursement be limited to performance of limited activities or all activities permitted by licensure? (This presupposes licensure.)

Quality Assurance—Elaborate mechanisms are now being developed to monitor the quality of physicians' services, thus there is a responsibility to consumers to continue similar efforts when reimbursing new, non-physician practitioners.

1. Should non-physician practitioners be paid only when deemed "medically necessary," that is, ordered by a physician; and, how will that determination be made?
2. Will the appropriate professional organization maintain a "registry" with standards to assure high degree of clinical proficiency?
3. Is the quality of services proposed to be offered by non-physician practitioners acceptable or better than that delivered by a physician?

The legal definition of practice for non-physician practitioners is normally so vaguely and broadly defined that it provides no assurance to consumers of the quality of service and competency of practitioners.

This is not presented as an exhaustive list of criteria and corresponding questions merely a minimum or starting point. As stressed earlier, once the membership of a review body defines their mission and develops operating guidelines, other criteria may evolve.

Chapter VI

SUMMARY OF KEY FINDINGS AND CONCLUSIONS

Key Findings

A synopsis of key findings is presented below. Each finding is followed by a page number which references the page in the text of the report which addresses the subject matter in more detail.

1. Within the last five years, there has been a trend among state legislatures in the United States to mandate additional health insurance benefits and coverage. (Page 4)

2. Future trends in state mandated benefits are likely to be, as follows:

   - There is likely to be an increasing number of mandated benefit bills passed which require additional coverage as an option;
   - The number of proposals to mandate practitioners' services will grow proportionately at a higher rate than other categories;
   - The current interest in cost containment will generate renewed interest in mandating out-of-hospital care coverage; and,
   - Social activist groups will attempt to use mandated benefit legislation as a means to indirectly influence public policy on controversial social and moral issues, such as abortion and women's rights. (Page 6)

3. Factors, identified during the course of this study, that may have contributed to the passage of mandated benefit legislation at an increased rate in many States are as follows:

   - Incomplete health insurance coverage. (Page 8)

- Expanded definition of health. (Page 10)
- Anti-physician sentiment. (Page 15)
- Expanded number and types of practitioners. (Page 14)
- Changing values and expectations of society. (Page 13)
- Pressure to reduce taxpayers' burden. (Page 17)
- Health insurance role as a change agent. (Page 17)

4. The general effects of expanding benefits/coverage by whatever means are threefold: (a) it usually lowers the out-of-pocket costs to the consumer for use of covered services; (b) when the out-of-pocket cost is lowered, the consumer has more cash to expend on non-covered health care services; and, (c) it assures a flow of revenue to providers. The more direct results are an increase in the price and the level of utilization of covered health care services. The financial impact on consumers is increased insurance premiums and out-of-pocket expenses. In time, the rise in health expenditures will generate yet another cry for expanded coverage. Thus, the risk is that legislative intervention (e.g., mandated benefits) starts a pernicious cycle which in the long run penalizes the disadvantaged groups which proponents purport to be helping. It goes like this. Greater insurance protection results in increased expenditures, which over the long run results in the need for more insurance protection. All the while premiums are increasing, thus demanding a progressively increasing share of the consumer's disposable income. Assuming a primary purpose of insurance is in-

come protection, the consumer gains little or nothing. This is very clear with the Medicare experience. This legislation was intended to protect the elderly's social security benefits and other retirement funds. However, the result has been that increasing expenditures has made the Medicare program so expensive that co-insurance and deductibles have been expanded and so has the need for supplementary medical insurance. The end result is that the short term gains in disposable income of the elderly in the sixties have been clearly wiped out in the seventies. (Page 22)

5. Expanded insurance coverage usually causes increased usage and an enriched product or service. This does not necessarily mean people will receive better care or gain improved access to needed health care services. Achieving these improvements is not possible through singular measures as expanded coverage, rather it demands more fundamental changes in the health care delivery system and new incentives for providers. Health insurance has clear limits as an instrument for remedying many of the very real problems within the health care delivery system in Virginia. The more predictable result of mandated benefit legislation is an improved flow of revenue to providers. (Page 25)

6. The process for reviewing proposed mandated benefit bills in the future must facilitate more forms of input; dedicate more time to the review process; and evaluate the proposals according to clearly defined criteria. (Page 30)

7. In the future mandated benefit legislation should not be passed unless there are specific provisions to insure controls on utilization and providers' fees and offsetting reductions in other

benefits. In other words some existing benefit should be eliminated to preclude costly redundancy. One example might be before mandating ambulatory surgery benefits, procedures that can be performed on an ambulatory basis (e.g., dilation and curretage) would no longer be covered under inpatient benefits. Another example might be that legislation mandating direct payment to clinical social workers for *selected* services would also prohibit payment by insurance carriers to psychiatrists for these services or only in areas of Virginia without practicing psychiatrists. Otherwise, without these tradeoffs health care expenditures will be needlessly increased. (Page 34)

8. A frequent objection to mandated benefit legislation is that it interferes with individual freedoms and free market forces. However, consumers are not informed, rational buyers of insurance as they might be in the purchase of an automobile. More appropriate government intervention might be to mandate minimum benefit standards to protect consumers from "inferior" policies. In addition, larger, multi-state employers will attempt to exempt themselves from state mandated benefits through self-insurance or legal proceedings to gain exemption under ERISA legislation. (Page 30)

9. The cost impact of each piece of mandated benefit legislation usually appears to be very small since monthly premium expense may only be increased by a dollar or less; however, when multiplied by the number of subscribers, the full impact on consumer spending is more dramatic. In the state of Maryland, a study showed that the cumulative effect of mandating 18 benefits over time, had increased consumer spending by

$23.5 million per year (this included Blue Cross subscribers only and did not include consumers with commercial insurance). (Page 35)

10. There is an increasing trend to mandate payment of non-physician practitioners. The proposed advantages of this legislation is often confronted with extreme controversy. The reason is that research and experience has shown that the proponents claims are not realized without carefully designed controls or other provisions in the legislation to insure successful achievement of the objectives.

    Health care practitioners (physicians or others) are not drawn to underserved (manpower) areas by merely mandating third-party payment. There are many other social and professional factors that are equally important. In fact, practitioners may find it possible to practice in over-supplied areas due to expanded purchasing power of the populace through mandated insurance payments. The effect often can be to discourage movement of practitioners from over-served or adequately served areas to the under-served areas.

    No one has demonstrated that there is any cost savings or stabilization in the increase of costs by reimbursing non-physician practitioners in addition to physicians under the same benefit package. Rather, research has clearly demonstrated that increased coverage of services result in increased utilization, thus total health care expenditures go up. A deceiving argument is that it must save insurance companies money when the subscriber is able to go to, for example, a clinical social worker, charging $25.00, rather than a psychiatrist, charging $50.00 for psychotherapy. The flaw in the argument is

that in a system where the provider (either psychiatrists or clinical social workers) is able to influence the price and the level of utilization, each is able to encourage enough utilization to assure an adeqaute income. The outcome is that total expenditures increase for three possible reasons: (1) the utilization of psychiatrists does not significantly decrease nor does their fees; (2) in time clinical social workers' fees begin to approach the fee levels of psychiatrists; and, (3) the utilization of clinical social workers' services increase. (Page 40)

11. Expanding coverage to non-physician practitioners under the broad scope of licensing laws may allow unqualified practitioners to enter the marketplace or result in the provision of unnecessary medical services to patients. The important point is that it is irresponsible to encourage non-physician practitioners to practice independently without the forms of control that we are now only beginning to exercise over physicians. (Page 40)

12. An acceptable alternative to the current process for deliberating on proposed mandated benefit legislation in the Virginia General Assembly should meet the following qualifications:

    - Expansion of state government must be minimized, thus cost to taxpayer.
    - Review mechanism must not intrude on decisionmaking autonomy of Virginia General Assembly.
    - Placement of review mechanism within government hierarchy and membership must be predicated on avoidance of dominance by any one interest group.

- Technical assistance in the areas of insurance and health care delivery must be available to membership of any body reviewing mandated coverage proposals.
- A more effective review process will require clearly defined and stated operating guidelines, mission statement, and evaluation criteria. (Page 44)

13. In the future proposed mandated benefit legislation should be evaluated according to criteria regarding unmet need, cost impact, provisions for controlling utilization and cost/fees and mechanisms for assuring quality. (Page 54)

Conclusion

The cost of health care in Virginia today has made adequate health insurance coverage an economic necessity for every citizen. No doubt with this fact in mind the Virginia legislature has legitimately mandated certain additional benefits to be included in all health insurance policies marketed in Virginia. The insurance industry has resisted most mandated benefits; consumers appear to be apathetic; and affected providers are always strong advocates. The diverse reactions of these three groups seem to attest to how fundamental and complex the task of defining and assuring adequate coverage.

Regretfully, mandated benefit legislation is initiated with sound motives, yet it is so piecemeal that additional problems are generated and the real deficiencies are not addressed. Mandated benefit legislation is symptomatic of real problems in the health care system, such as: the free market system will not assure adequate coverage for all the privately insured; and, the consumer is an uninformed purchaser unable to make "best buy" decisions. There is a need for third party intervention to protect consumers from significant gaps in coverage that expose them to unnecessary financial risk.

I. *The General Assembly of Virginia should temporarily, if not permanently, place a moratorium on mandating additional benefits or coverage in health insurance policies. The critical need is to examine the adequacy of health insurance coverage in Virginia and then consider passage of minimum benefit standards legislation.*

A. A moratorium on passage of mandated benefit legislation should only be removed once a comprehensive evaluation of health insurance coverage is performed and problems are identified.

B. In the future to minimize the cost impact and assure freedom of choice for consumers, additional benefits should be mandated only as an "option."

II. *Proposals to legislatively mandate additional benefits and/or coverage of non-physician practitioner services can have such a tremendous impact on costs and quality that each must receive an exhaustive examination according to uniform evalaution criteria.*

A. The evaluation criteria presented on pages 54-57 should be utilized in the review of any proposal to mandate additional benefits.

B. If the time or the needed inputs cannot be facilitated in the current review process, then a more formal review mechanism should be organized. The Bureau of Insurance Advisory Commission (Alternative #3, Chapter V) is preferred.

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APPENDIX A

MATERNITY COVERAGE
MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1976	Complications of Pregnancy
Colorado	1975	Maternity Benefits
Georgia	1977	Complications of Pregnancy
Idaho	1975	Maternity Benefits
	1976	Involuntary Complications of Pregnancy
Maine	1975	Unmarried Maternity
Maryland	1975	Maternity Benefits
	1975	Unmarried Maternity
Minnesota	1973	Unmarried Maternity
Missouri	1973	Unmarried Maternity
Nevada	1977	Complications of Pregnancy
New York	1976	Maternity Coverage
Oregon	1973	Unmarried Maternity
	1977	Civil Rights
Texas	1977	Insurance Department Regulation; Coverage of pregnancy in individual health policies made optional

Source: Blue Cross and Blue Shield Associations

OUT-OF-HOSPITAL-CARE MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Arizona	1971	Out-of-Hospital
Connecticut	1976	Home Health Care
Florida	1977	Ambulatory Services
Maine	1977*	Home Health Care
Minnesota	1976	Ambulatory-Surgical Coverage
Missouri	1975	Ambulatory-Surgical Centers
Nevada	1975	Home Health Care
New Jersey	1966	Hospital-Related Health Care Service or Supplies
	1970	Health Care Services
New Mexico	1977*	Home Health Care
New York	1972	Home Health Agencies and Services
	1973	Home Health Care
	1975	Home Health Care
	1976	Pre-admission Testing; Ambulatory Care
	1977	Medicare Supplements
Ohio	1972	Kidney Dialysis
Oklahoma	1976	Ambulatory Surgical Centers
Utah	1976	Ambulatory Surgical Facilities
Vermont	1976	Home Health Care

* Law requires the offer of coverage for the benefit(s) identified.
Source: Blue Cross and Blue Shield Associations

CATASTROPHIC COVERAGE
MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Arizona	1974	(repealed 1976)
Connecticut	1975*	Comprehensive Health Care
	1976	Amendment
	1977	Amendment
	1977	Amendment-Second Surgical Opinion
Hawaii	1974	Prepaid Health Care Act
Minnesota	1976	Comprehensive Health Expense Protection
Rhode Island	1974	Catastrophic Health Insurance
	1975	Plan Amendment

* Law requires the offer of coverage for the benefit(s) identified.

Source: Blue Cross and Blue Shield Associations

MISCELLANEOUS BENEFITS
MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1970	Sterilization
	1974*	Employment of Physically Handicapped
Delaware	1974	Unfair Trade Practices: Age Discrimination
Illinois	1975	Rape Victims
Louisiana	1974	Nongroup Policies to Age 65
Maryland	1975	Blood Products
New York	1975	Insurance Department Regulation: Reconstructive Surgery
	1976	Pre-admission Testing
	1976	Second Surgical Opinions
	1976	Insurance Department Bulletin: Second Surgical Opinions
North Carolina	1977	Mentally and/or Physically Handicapped
Ohio	1976	Unfair Trade Practices: Discrimination of Sex or Marital Status
Wisconsin	1975	Kidney Disease and Organ Transplant

* Law requires the offer of coverage for the benefit(s) identified.

Source: Blue Cross and Blue Shield Associations

CONTINUED COVERAGE
MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1971	Dependents' Coverage
	1976	Disabled Employees
	1976	Divorced Dependents
	1976	Surviving Spouse
	1977	Contract Replacement
Connecticut	1975	Extended Coverage
Florida	1974	Replacement Coverage
Idaho	1975	Disabled Individuals
Illinois	1976	Divorced Spouse
Louisiana	1977	Contract Replacement
Maryland	1977	Conversion Privilege: Divorced or Widowed Spouses
Massachusetts	1975	Laid-off Employees
Minnesota	1973	Disabled Employees
	1973	Survivor(s)
	1973	Government Hospital Services
	1974	Terminated Employees
	1975	Amendment: Terminated Employees
	1976	Amendment: Conversion Privilege
	1977	Conversion Privilege: Divorced Spouses
	1977	Conversion Privilege: Cancellation or Termination for the entire group
Missouri	1969	Conversion Privilege: Survivors
New Jersey	1976	Survivors
	1976	Amendment
New York	1971	Conversion Privilege
Ohio	1975	Conversion Privilege
Oklahoma	1975	Extended Coverage
Oregon	1977	Contract Replacement
Texas	1977	Extended Coverage: Group Coverage During Strikes

Source: Blue Cross and Blue Shield Associations

MENTAL AND/OR NERVOUS CONDITIONS MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
California	1973*	Group Coverage
	1976	Social Workers' Services
Colorado	1976	Mental Illness Minimum Benefits
Connecticut	1974	Mental and/or Nervous Conditions
	1976	Amendment to 1974 Law
Illinois	1974	Mental Illness
	1975	Mental and/or Physical Illness
	1977*	Mental, Emotional, or Nervous Conditions
Louisiana	1975*	Mental Care
Maryland	1973	Mental Illness Minimum Benefits
	1975	Mental Benefits
	1976*	Partial Psychiatric Hospitalization
Massachusetts	1973	Mental or Nervous Conditions
Minnesota	1975	Mental or Nervous Disorders
	1975	Emotionally Disturbed Children
	1975	Outpatient Mental Health Treatment
New Hampshire	1975	Mental Care
	1976	Amendment to 1975 Law
New York	1968	Medicaid Benefits Extension
	1977*	Mental Care Coverage
North Carolina	1975	Hospitalization in Public Institutions
North Dakota	1975	Mental Illness, Alcoholism and Drug Addiction *
Ohio	1976	Hospitalization in Tax Supported Institutions
Oregon	1973	Mental Illness Minimum Benefits
Vermont	1976*	Mental Coverage
Virginia	1976	Mental Disorders
	1977*	Outpatient Psychiatric Benefits
Wisconsin	1975	Mental and Nervous Disorders

* Law requires the offer of coverage for the benefit(s) identified.

Source: Blue Cross and Blue Shield Associations

ALCOHOLISM AND/OR DRUG ABUSE MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Colorado	1976*	Alcoholism
Connecticut	1974	Alcoholism
	1976	Drug Overdose
	1977*	Alcoholism: Outpatient Treatment
Hawaii	1976	Alcoholism and Drug Addiction
Illinois	1973	Alcoholism
Kansas	1977*	Alcoholism
Louisiana	1974	Alcoholism
Massachusetts	1973*	Alcoholism
Minnesota	1973	Alcoholism and Drug Addiction
	1976	Alcoholism and Drug Addiction
Mississippi	1974	Alcoholism
Missouri	1977	Alcoholism
Nevada	1975	Alcoholism and Drug Addiction
New Jersey	1977	Alcoholism
North Dakota	1975	Alcoholism and Drug Addiction
Oregon	1975	Alcoholism
	1977*	Alcoholism: Individual Policies
South Dakota	1976	Alcoholism
Virginia	1977*	Alcoholism and Drug Addiction
Washington	1974	Alcoholism
Wisconsin	1971	Alcoholism
	1975	Alcoholism and Drug Abuse

* Law requires the offer of coverage for the benefit(s) identified.
Source: Blue Cross and Blue Shield Associations

PRACTITIONERS' SERVICES
MANDATED COVERAGE LEGISLATION

States	Year of Bill's Passage	Description of Coverage
Alabama	1966	Optometrists
Alaska	1976	Optometrists
Arizona	1977	Dental Services
Arkansas	1975	Licensed Health Professionals
	1975	Podiatrists
	1975	Psychologists
California	1974	Psychologists
	1976*	Orthomolecular Medicine
Connecticut	1975	Optometrists
	1975	Naturopathic Physicians
	1975	Dentistry or Dental Medicine
	1975	Psychologists
Florida	1974	Chiropractic Services
	1974	Podiatrists
	1974	Optometrists
	1976	Chiropractic Services
Indiana	1974	Dentists, Podiatrists, Osteopaths, Optometrists and Chiropractors
Kansas	1973	Optometrists, Podiatrists and Dentists
	1973	Licensed Practitioners
	1974	Psychologists
Louisiana	1974	Psychologists
	1974	Dentists
	1975	Chiropractors
Maine	1975	Psychologists
	1975	Dentists and Dental Hygienists
Maryland	1973	Psychologists
	1977	Social Workers
Massachusetts	1975	Dentists
Minnesota	1973	Chiropractors
	1974	Osteopaths, Optometrists or Chiropractors
	1976	Optometrists
	1976	Podiatrists

* Law requires the offer of coverage for the benefit(s) identified.

States	Year of Bill's Passage	Description of Coverage
Mississippi	1974	Psychologists
Nebraska	1974	Psychologists
	1975	Dental Services
Nevada	1975	Chinese Medicine
New Hampshire	1975	Oral Surgeons
New Jersey	1973	Psychologists
New Mexico	1977	Attorney General Ruling: Freedom of Choice of Practitioners
New York	1971	Psychiatrists and Psychologists
	1973	Physical Therapists
	1975	Dentists, Oral Surgeons and Doctors of Dental Surgery
	1975	Psychologists
	1977	Social Workers
North Carolina	1973	Chiropractors
	1977	Psychologists
Ohio	1973	Dentists
	1974	Psychologists
Oklahoma	1976	Podiatric and Psychological Services
Oregon	1976	Psychologists
Tennessee	1974	Dentists
	1974	Psychologists
Texas	1977	Pediatric Services
	1977	Psychologists
Utah	1975	Optometrist, Chiropractor, Chiropodist, Psychologist or Social Worker
Virginia	1977	Insurance Commissioner Order: Psychologists Optometrists Opticians
Wisconsin	1974	Chiropractors
	1974	Optometrists

Source: Blue Cross and Blue Shield Associations

DEPENDENT COVERAGE
MANDATED COVERAGE LEGISLATION

NEWBORNS

All laws require coverage of newborns from the moment of birth.

States	Year of Bill's Passage	Description of Coverage
Alaska	1975	
Arizona	1974	
Arkansas	1975	
California	1971	
Colorado	1975	
Connecticut	1974	
Delaware	1974	
Florida	1974 1977	Amended to include national accounts
Hawaii	1974	
Idaho	1974	
Illinois	1975	
Indiana	1976	
Kentucky	1976	
Louisiana	1973	
Maine	1976	
Massachusetts	1974	
Minnesota	1973	
Mississippi	1974	
Missouri	1974	
Nebraska	1975	
Nevada	1976	
New Hampshire	1975	
New Jersey	1975 1975	Amended to include children of unwed mothers

States	Year of Bill's Passage	Description of Coverage
New Mexico	1975	
	1977	Transportation of newborns and high risk pregnant women to tertiary-care facilities
New York	1977	
North Carolina	1973	
Ohio	1974	
Oklahoma	1976	
Oregon	1975	
Pennsylvania	1976	
South Carolina	1974	
South Dakota	1976	
	1977	Amended to include renewed contracts
Tennessee	1974	
Texas	1973	
Vermont	1976	
Virginia	1976	
Washington	1974	
West Virginia	1975	
Wisconsin	1975	
	1977	Insurance Department Regulation

MENTALLY AND/OR PHYSICALLY HANDICAPPED CHILDREN

All laws require that coverage be provided for dependents who are both incapable of self-sustaining employment because of mental retardation or physical handicap, and who are chiefly dependent upon the subscriber for support.

States	Year of Bill's Passage	Description of Coverage
Arizona	1977	Age limitations may not be applied to mentally or physically handicapped dependents
Arkansas	1969 1975	
California	1971	
Connecticut	1971	
Georgia	1972	
Hawaii	1967	
Idaho	1972	
Illinois	1967	
Indiana	1969 1971	
Louisiana	1972 1974	
Maryland	1977	
Massachusetts	1956	
Michigan	1966	
Minnesota	1969	
New Hampshire	1969	
New Jersey	1966	
New Mexico	1969	
New York	1965	
North Carolina	1969 1971 1973 1977	

States	Year of Bill's Passage	Description of Coverage
Ohio	1971	
Pennsylvania	1968	
South Carolina	1970	
Tennessee	1969	
Washington	1969	
OTHERS		
California	1976	Spouses
Louisiana	1974	Students
Massachusetts	1975	Adopted Children
Nebraska	1976	Students

Source: Blue Cross and Blue Shield Associations

APPENDIX B

ALTERNATIVES - MANDATED COVERAGE REVIEW MECHANISM

ALTERNATIVES / ELEMENTS	(1) STATUS QUO	(2) REQUIRED REVIEW BY HSC	(3) ADVISORY COMMISSION BUREAU OF INSURANCE	(4) VERMONT HEALTH CARE COST CONTAINMENT COMMISSION	(5) VERMONT HEALTH SERVICES COST REVIEW COMMISSION	(6) ADVISORY COMMISSION SECRETARY OF HUMAN RESOURCES	(7) ONE-YEAR STUDY COMMISSION - MANDATE REVIEWS BENEFIT PACKAGE	(8) HSC, FREE STANDING MANDATED COVERAGE REVIEW BY HSC
Structure		Located in State Health Dept.	Located in Bureau of Insurance	Existing by Joint Resolution; Limited Existence	Existing	Located in Executive Branch	Free-Standing; Located in Legislative Branch	Located in Legislative Executive Branch
Membership	All Legislators	Specified by PL 93-641	Appointed by Governor 1 Employer 2 Consumers 2 Legislators 1 Chairman-HSC 1 Chairman-PSD 1 Board of Commerce Ex-officio 1 Commissioner, Health Dept. 1 Insurance Commissioner	Appointed by Governor Consumers Legislators Ex-officio - Health Dept., Mental Health, Insurance Commissioners	Appointed by Governor 3 Consumers 3 Health Care Administrators 1 R/IB 1 Commercial Insurance 1 Commissioner of Health	Appointed by Governor 1 Employer 2 Consumers 2 Legislators Board of Commerce 1 Chairman-HSC 1 Chairman-PSD Ex-officio Commissioner of Insurance Secretary of Human Res.	Appointed by Governor 2 Consumers 1 R/IB 1 Commercial Insurance, Health Ins. 1 Employer 1 Legislator 1 Chairman-HSC 1 Chairman-PSD	Appointed by Governor 1 Employer 2 Consumers 2 Legislators 1 Chairman-HSC 1 Chairman-PSD 1 Board of Commerce Ex-officio 1 Commissioner, Health Dept. 1 Commissioner, Mental Health 1 Insurance Commissioner
Scope of Activities		Advisory to General Assembly per Request	Advisory to Governor and General Assembly per Request and Investigative Power	Unlimited Investigative Powers RE: Costs, Health Insurance	Review Hospital Charges; Investigative Powers; Advise Governor and General Assembly	Advisory; Investigative Powers	Study Needs and Identify Gaps in Coverage	Advisory; Review Proposed Bills; Investigative Power
Review Process	Intervention in Legislative Committee	Referred by Committee; Public Hearing; Staff Study; HSC Recommendation	Referred by Committee or Other Agencies and Interested Parties (After Approval); Public Hearing; Staff Report; Recommendation	Referred by Committee or Other Parties (After Approval); Public Hearing; Staff Report; Recommendation	Voluntary Filing of Hospital Charges; Law on PA	Referred by Legislative Committee	Public Hearing; Staff Report; Recommendation	Referred by Committee of Petitions by Outside Parties (Insurance); Public Hearing; Staff Report Recommendation
Source of Expert Staff	JLAC, State Agency Staff	Bureau of Health Planning	Bureau of Insurance; Bureau of Planning	Bureau of Insurance; Department of Health; Department of Mental Health	Hire Own Staff	Secretary of Human Resources	Hire Own Staff	Hire Own Staff

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APPENDIX C

ATTACHMENT A
(Maryland)

EFFECT OF MANDATED COVERAGES ON HEALTH INSURANCE PREMIUMS

The Economic Matters Committee notes that the General Assembly in the last decade has passed legislation mandating coverage of 18 different health insurance benefits by nonprofit health service plans. The Committee finds in every legislative Session additional bills to mandate insurance coverage for additional services. The question naturally arises as to what effect these mandated coverages have on the premiums paid by the health insured.

The Committee investigated this issue during the summer and held a hearing on HB 1185, which would mandate insurance coverage for the services of nurses and nurse mid-wives. The Committee requested Blue Cross and Blue Shield of Maryland to study and make a report to the Committee on the cost for the mandated coverages passed by the Legislature in the last decade. Blue Cross and Blue Shield reported to the Committee on October 18, 1977, and a copy of the report is enclosed. It appears from the data in the Blue Cross and Blue Shield Report that the mandated coverages passed by the Legislature in the last decade may have increased the cost of health care to the health insurance policyholder without necessarily improving the quality of where a health service is added as a benefit paid by insurance, the incidence of the unnecessary utilization of that service may increase. The Committee questions the ability of the average policyholder to afford these mandated coverages when one considers that there is doubt as to whether his health care has been improved.

The total aggregate cost of all programs mandated by legislation is approximately $39 million, of which $12.5

million would be incurred by Blue Cross subscribers if they elected to purchase the coverage which Blue Cross is required to offer on an optional basis.

The Committee concludes that it is not certain that mandating health insurance benefits improves the quality of health care or reduces health costs by offering a choice to the policyholder. The committee notes that in fact health care may not have improved while health costs may have increased because of mandated coverages. The committee concludes that more information is needed on this subject and that all legislation attempting to expand the categories of mandated health insurance benefits should be examined in this light.

The Committee received testimony at the hearing on HB 1185, that at present there are no legal definitions of the occupations of Nurse Practitioner, Nurse Midwife, or Nurse Anesthetist.

Independent of the merit of this bill, the Committee recommends that no action be taken on HB 1185 until the appropriate State department issues rules and regulations defining the occupation and duties of a Nurse Practitioner, Nurse Midwife, and Nurse Anesthetist.

Exhibit D

October 18, 1977

MEMORANDUM

To: Honorable John W. Wolfgang

From: Kenneth Masters and F. M. Gloth, Jr.

Subject: Benefits Mandated by the General Assembly

The attached document lists benefits mandated by the General Assembly for nonprofit health service plans. This document gives a brief description of each of the 18 benefits that have been mandated during past years, as well as the cost of such benefits per month per corporate membership.

Based on the attached rate increments and on the estimate of the number of members affected by each of the mandated benefits, the total maximum cost to Blue Cross subscribers would be about $23.5 million per year. An additional $12.5 million in cost would be incurred by Blue Cross subscribers if they elected to purchase the coverage which Blue Cross is required to offer on an optional basis.

The Blue Shield cost for mandated benefits would be about $3 million per year.

The total aggregate cost of all programs mandated by legislation would be approximately $39 million.

If you have any questions concerning the above or the attached document, we will try to answer them for you.

ECONOMIC MATTERS COMMITTEE EFFECT

BENEFITS MANDATED BY THE GENERAL ASSEMBLY

1. *Mental and Nervous (Inpatient) (Sec. 354C)*

This section requires that all of our policies include benefits for expenses arising from acute mental illnesses and emotional disorders which are subject to significant improvement through short-term therapy. Minimum benefits for inpatient confinement at a hospital must cover at least 30 days in any calendar year or benefit period.

Impact is on Blue Cross. $.85

2. *Mental and Nervous (Major Medical) (Sec. 354D)*

The second half of this section requires the provision of a Major Medical mental and nervous benefit which must be at least 50% of the benefits which the policy provides for other type illnesses.

Primary impact is on Blue Cross. $.70

3. *Blood Products (Sec. 354E)*

This section prohibits Blue Cross from excluding payments for blood products which would otherwise be covered. It does not apply to whole blood or concentrated red blood cells.

Impact is on Blue Cross. $.07

4. *Maternity Hospitalization (Sec. 354F)*

This section mandates the provision of the same benefit for maternity hospitalization as for any other covered illness if the original policy provided some hospitalization benefits for normal pregnancy. Section

does not require Blue Cross to provide or offer maternity benefits in the first instance in any policy.

Impact is on Blue Cross.
If maternity is provided. $.95

5. *Maternity Benefits/Full Coverage (Sec. 354G)*

This section mandates the provision of maternity benefits to all group members and their dependents regardless of marital status. These benefits must be identical to the benefits, if any, provided in the basic group contract. Benefits included are pregnancy, childbirth, disability, and medical surgical care.

Impact on both Corporations.

Blue Cross	$.11
Blue Shield	$.05

6. *Maternity Benefits/Full Coverage/Individuals (Sec. 354H)*

This section requires Blue Cross and Blue Shield to offer maternity benefits to individuals regardless of marital status.

Impact is on both Corporations.

Blue Cross	$.16
Blue Shield	$.12

7. *Alcoholic Rehab. (Sec. 354I)*

This section requires Blue Cross in all group contracts issued after July 1, 1976 to offer benefits for alcoholic rehabilitation programs licensed by the Department of Health and Mental Hygiene. Minimum benefits required are not less than 30 days or partial days of inpatient care in any period of 12 consecutive months. Two outpatient visits are deemed equivalent to one day's care.

Impact is on Blue Cross. If offered $.75

8. *Psychiatric Day Care (Sec. 354J)*

This section requires offering benefits for partial hospitalization for psychiatric care to all groups with over 25 members. Effective date was January 1, 1977. "Partial hospitalization" is defined to include treatment at a hospital, psychiatric day care center or a community mental health facility.

Impact is on Blue Cross. If offered $.20

9. *Social Worker (354K)*

This section mandates provision of benefits for services within the scope of practice of a duly licensed social worker whether those services are performed by a medical doctor or a social worker so long as the patient is referred to the social worker by the physician and so long as the original policy provides coverage for activities which are within the scope of a licensed certified social worker. Effective date is January 1, 1978.

Impact is on both Corporations.

Blue Cross	$.06
Blue Shield (limited to Outpatient Psychiatric Endorsement only)	$.02

10. *Home Health Care (Art. 48A Sec. 470J)*

This bill requires that after July 1, 1977 Plan claim offer coverage for home health care. "Home Health Care" is defined to plan the continued care and treatment of the insured if he would otherwise have had to remain in an institution and if the plan of treatment is established and developed in writing by a physician. Minimum coverage of at least 40 home care visits in any calendar year or continuous 12 month period is required. Up to four hours of

home health care services are to be considered as one home care visit.

Impact is on Blue Cross. No cost determinable

11. *Podiatrists (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services legally rendered by podiatrists that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Shield	$.10
Blue Cross	$.02

12. *Optometrists (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services legally rendered by optometrists that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Cross	$.02
Blue Shield	$.02

13. *Chiropractors (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services legally rendered by chiropractors that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Shield	$.02
Blue Cross Not determinable (i.e. less than $.009)	

14. *Psychologists (Sec. 354(a))*

This section requires that nonprofit health service plans in Maryland provide benefits for those services

legally rendered by psychologists that would be covered if rendered by doctors of medicine.

Impact is on both Corporations.

Blue Shield	$.04
Blue Cross	$.01

15. *Handicapped Children (Sec. 354(a-1))*

This section requires that any unmarried child who at the time of reaching the limiting age is incapable of self-support due to a physical or mental incapacity and who is covered under a policy as a dependent must remain covered as long as the incapacity continues or until the coverage of the parent etc. is terminated.

Impact is on both Corporations.

Blue Cross	$.05
Blue Shield	$.02

16. *Conversion Rights (Sec. 354J)*

This section requires that in all group contracts which have conversion privileges, a covered dependent spouse be offered the same conversion rights in the event the coverage ceases due to death or termination of the marriage.

Impact on both Corporations.

Blue Cross	$.02
Blue Shield	$.01

17. *Female Cancer Exam (Art. 43 Sec. 556F)*

This section requires that all female hospital inpatients over 18 be given a Pap-Smear test unless countermanded by the attending physician or unless it was performed within a year of admission. The patient at all times may refuse the test.

Primary impact is on Blue Cross $1.50

18. *State Hospitals (Sec. 354A)*

This section requires Blue Cross to provide benefits for covered services rendered in a state hospital.

Impact is on Blue Cross.	$.14

Footnote: All figures are estimated cost per month per composite membership, based on 1.5 million members.

Membership of Blue Cross Plans
December 31, 1978
(Continued)

PLAN	REGULAR		COMPLEMENTARY		TOTAL	PER CENT OF PLAN AREA POPULATION ENROLLED**
	GROUP*	NONGROUP	GROUP	NONGROUP		
VA, RICHMOND	1,229,969	107,784	28,662	65,023	1,431,438	41.2
VA, ROANOKE	294,662	43,465	4,894	29,043	372,064	39.2
WA, SEATTLE	659,251	45,200	11,000	31,742	747,193	18.7
WV, CHARLESTON	213,371	38,959	7,097	23,767	283,194	27.8
WV, PARKERSBURG	47,284	2,816	1,322	4,159	55,581	45.8
WV, WHEELING	112,231	9,704	4,953	10,238	137,126	24.6
WI, MILWAUKEE	1,252,122	47,739	64,104	109,389	1,473,354	31.2
WY, CHEYENNE	92,922	21,088	497	7,977	122,484	28.7
PR, SAN JUAN	292,515	6,586	—	1,404	300,505	9.5
HEALTH SERVICE, INC.‡	20,505	138	—	—	20,643	—
TOTAL UNITED STATES	68,198,294	6,161,675	2,923,262	5,973,370	83,256,601	37.6

Canada and Jamaica

ALTA., EDMONTON	425,629	390,917	—	—	816,546	41.1
MAN, WINNIPEG@						
N.B., MONCTON	405,564	80,836	—	—	486,400	21.7
ONT., DON MILLS	2,369,933	487,754	—	—	2,857,687	33.4
QUE., MONTREAL	693,323	70,384	—	—	763,707	12.1
TOTAL CANADA	3,894,449	1,029,891	—	—	4,924,340	25.8
JAMAICA, KINGSTON	76,131	2,164	—	—	78,295	3.6
TOTAL BLUE CROSS PLANS	72,168,874	7,193,730	2,923,262	5,973,370	88,259,236	36.4

* Includes enrollment for Federal Employees Health Benefits Program.
** United States and Canada population figures taken from *Sales and Marketing Management*, "Survey of Buying Power," (July 1978) and projected to December, 1978.
Population of Puerto Rico taken from the *Puerto Rico Planning Board*, "Socio-Economic Statistics, Fiscal Years 1940, 1950, 1960-1977" and projected to December, 1978.
Population of Jamaica taken from *U.S. Bureau of the Census*, "County Demographic Profile: Jamaica 1977" and projected to December, 1978.
‡ A stock insurance company wholly owned by the Blue Cross Association which assists in the enrollment and servicing of national accounts.
@ December 31, 1978 enrollment report was not received prior to publication.

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Blue Cross Plan Financial Data
January 1, 1978 to December 31, 1978
(Continued)

PLAN	TOTAL ASSETS	TOTAL LIABILITIES	RESERVES	NET*** SUBSCRIPTION INCOME	TOTAL*** INCOME	CLAIMS*** EXPENSE	ADMINISTRATIVE*** EXPENSE	NET*** INCOME	% OF NET*** SUBSCRIPTION INCOME	
									CLAIMS EXPENSE	ADMIN. EXPENSE
NE, OMAHA**	65,956,000	29,910,000	36,046,000	124,136,000	126,552,000	105,484,000	8,031,000	13,037,000	85.0	6.5
NH, CONCORD**	50,520,000	31,498,000	19,022,000	138,068,000	141,022,000	124,230,000	9,690,000	7,102,000	90.0	7.0
NJ, NEWARK	265,650,000	208,933,000	56,717,000	616,189,000	627,289,000	575,592,000	22,320,000	29,377,000	93.4	3.6
NM, ALBUQUERQUE**	21,005,000	11,543,000	9,462,000	47,575,000	48,684,000	42,493,000	3,842,000	2,349,000	89.3	8.1
NY, ALBANY	32,770,000	28,725,000	4,045,000	113,154,000	114,276,000	109,963,000	6,684,000	−2,371,000	97.2	5.9
NY, BUFFALO@	48,548,000	30,883,000	17,665,000	145,836,000	148,164,000	135,063,000	7,987,000	5,114,000	92.6	5.5
NY, NEW YORK**	471,507,000	390,367,000	81,140,000	1,412,233,000	1,419,421,000	1,268,233,000	106,849,000	44,539,000	89.8	7.6
NY, ROCHESTER	65,770,000	39,922,000	25,848,000	134,765,000	137,885,000	119,681,000	4,499,000	13,705,000	88.8	3.3
NY, SYRACUSE	35,244,000	29,581,000	5,663,000	78,719,000	79,561,000	76,174,000	3,991,000	— 604,000	96.8	5.1
NY, UTICA	15,423,000	10,182,000	5,241,000	34,246,000	34,962,000	33,035,000	1,373,000	554,000	96.5	4.0
NY, WATERTOWN	2,679,000	1,687,000	992,000	5,148,000	5,304,000	4,964,000	251,000	89,000	96.4	4.9
NC, DURHAM**	202,222,000	110,367,000	91,855,000	386,435,000	397,656,000	355,937,000	22,321,000	19,396,000	92.1	5.8
ND, FARGO	29,478,000	14,240,000	15,238,000	64,812,000	66,130,000	57,277,000	3,162,000	5,691,000	88.4	4.9
OH, CINCINNATI	233,533,000	114,936,000	118,597,000	451,745,000	463,511,000	412,794,000	18,102,000	32,615,000	91.4	4.0
OH, CLEVELAND	157,413,000	107,531,000	49,882,000	363,408,000	365,097,000	343,666,000	16,522,000	4,909,000	94.6	4.6
OH, COLUMBUS	69,707,000	44,618,000	25,089,000	121,063,000	123,457,000	107,236,000	5,518,000	10,703,000	88.6	4.6
OH, TOLEDO	80,443,000	47,440,000	33,003,000	152,267,000	155,875,000	136,061,000	5,970,000	13,844,000	89.4	3.9
OK, TULSA**	77,323,000	50,146,000	27,177,000	155,168,000	156,242,000	140,741,000	11,760,000	5,741,000	90.7	7.6
OR, PORTLAND*	78,760,000	50,846,000	27,914,000	160,938,000	164,272,000	143,708,000	12,499,000	8,065,000	89.3	7.8
PA, ALLENTOWN	33,468,000	15,196,000	18,272,000	59,221,000	60,824,000	54,499,000	2,462,000	3,863,000	92.0	4.2
PA, HARRISBURG	97,632,000	59,557,000	38,075,000	154,390,000	159,434,000	144,486,000	5,767,000	9,181,000	93.6	3.7
PA, PHILADELPHIA	215,605,000	127,612,000	87,993,000	426,150,000	437,924,000	383,074,000	15,033,000	39,817,000	89.9	3.5
PA, PITTSBURGH	244,504,000	160,732,000	83,772,000	502,029,000	509,944,000	470,346,000	17,884,000	21,714,000	93.7	3.6
PA, WILKES-BARRE	51,294,000	31,826,000	19,468,000	105,844,000	107,989,000	96,610,000	3,126,000	8,253,000	91.3	3.0
RI, PROVIDENCE	48,413,000	33,218,000	15,195,000	129,275,000	131,138,000	113,036,000	4,830,000	13,272,000	87.4	3.7
SC, COLUMBIA**	68,115,000	49,091,000	39,024,000	183,512,000	186,321,000	163,935,000	10,460,000	11,926,000	89.3	5.7
TN, CHATTANOOGA**	186,612,000	98,012,000	88,600,000	265,408,000	274,440,000	249,745,000	15,295,000	9,400,000	94.1	5.8
TN, MEMPHIS**	28,382,000	19,691,000	8,691,000	60,946,000	61,527,000	54,018,000	4,172,000	3,337,000	88.6	6.9
TX, DALLAS*	214,506,000	152,239,000	62,267,000	487,198,000	496,997,000	464,532,000	28,562,000	5,903,000	95.4	5.9
UT, SALT LAKE CITY	14,334,000	11,112,000	3,222,000	49,313,000	49,761,000	45,830,000	2,362,000	1,569,000	92.9	4.8

*A Blue Cross only Plan; includes Medical/Surgical data.
**A Blue Cross and Blue Shield Plan; the Plan reports identical financial data to the Blue Shield Association.
***Includes underwritten business only.
@The Jamestown, New York Plan merged with the Buffalo, New York Plan during the second quarter 1978.

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Membership of Blue Shield Plans
December 31, 1978
(Continued)

PLAN	TOTAL GROUP*	TOTAL NONGROUP	TOTAL MEDICARE COMPLEMENTARY COVERAGE	TOTAL REGULAR BUSINESS	TOTAL FISCAL ARRANGEMENTS◉	TOTAL REGULAR BUSINESS & BUSINESS UNDER FISCAL ARRANGEMENTS◉◉	PER CENT OF PLAN AREA POPULATION ENROLLED**
WA, WENATCHEE	18,227	1,777	3,494	23,498	8,241	28,245	45.48
WV, CHARLESTON	201,894	38,773	30,846	271,513	—	271,513	27.33
WV, CLARKSBURG	12,002	4,088	5,847	22,837	—	22,837	13.29
WV, MORGANTOWN	6,737	4,766	2,611	14,114	—	14,114	14.14
WV, PARKERSBURG	45,903	2,817	5,478	54,198	—	54,198	38.06
WV, WHEELING	104,538	9,606	15,191	129,335	—	129,335	27.16
WI, MADISON	426,333	26,554	44,948	497,835	731,081	1,183,968	25.09(d)
WI, MILWAUKEE	1,134,691	46,873	169,130	1,350,694	120,337	1,386,466	29.38
WY, CHEYENNE	91,022	20,969	8,474	120,465	—	120,465	28.18
PR, SAN JUAN	303,301	25,961	11,026	340,288	145,454	474,716	14.95
MEDICAL INDEMNITY OF AMERICA‡	125,563	40	—	125,603	—	125,603	—
TOTAL	56,414,731	5,785,241	7,827,550	70,127,522	19,699,102	84,010,022	38.57

*Includes enrollment for Federal Employees Health Benefits Program.
**Population figure taken from *Sales and Marketing Management*, "Survey of Buying Power," (July 1978) and projected to December, 1978.
◉Medicare Part B, non-underwritten Medicaid, CHAMPUS and other welfare.
◉◉This total has been adjusted to eliminate the double counting of enrollees under Medicare Complementary and Medicare Part B.

‡ A stock insurance company wholly owned by the Blue Shield Association which assists in enrollment and servicing of national accounts.
(d) Includes CHAMPUS in Arkansas, Illinois, Iowa, Kansas, Minnesota, Missouri, North Dakota, Oklahoma and South Dakota; population figure is Wisconsin only.

Affiliated Plans

Affiliated Plans: Vancouver, B.C. London, England; Moncton, N.B.; Regina, Saskatchewan; Saskatoon, Saskatchewan.

EXHIBIT 22

NATIONWIDE ADDITIONAL ANNUAL PREMIUM COST OF MANDATED BENEFITS

(Based on Colorado Experience of Blue Cross-Blue Shield)

A) Additional premium cost per individual employee for 16 mandated benefits = $91.80

B) Number of individual employees nationwide with group hospital coverage = 55,015,000

C) Nationwide additional premium cost of mandated benefits (AxB) = $5,050,377,000

EXHIBIT 23

NATIONWIDE ADDITIONAL ANNUAL PREMIUM COST OF MANDATED BENEFITS

Maryland Experience of Blue Cross-Blue Shield

A) Additional premium cost for hospital coverage = $23,500,000

B) Number of covered persons = 1,500,000

C) Additional premium cost for hospital coverage per covered person (A÷B) = $15.67

D) Additional premium cost for medical coverage = $3,000,000

E) Additional premium cost for medical coverage per covered person (D÷B) = $2.00

Nationwide Projection

F) Number of persons nationwide with group hospital coverage = 135,942,000

G) Nationwide additional premium cost of mandated benefits for group hospital coverage (CxF) = $2,130,211,000

H) Number of persons nationwide with group medical coverage = 129,308,000

I) Nationwide additional premium costs of mandated benefits for group medical coverage (ExH) = $258,616,000

J) Nationwide additional premium cost of mandated benefits (G+I) = $2,388,827,000

EXHIBIT 24

METROPOLITAN LIFE INSURANCE
"Administrative Services Only" ("ASO") Contracts

Year	Number of New ASO Contracts Issued	Total Claims*
1972	2	8,537,000
1973	1	1,207,000
1974	1	15,288,000
1975	3	2,517,000
1976	8	85,796,000
1977	9	54,213,000
1978	9	25,542,000
1979	18	35,624,000
Total	51	228,724,000

* These figures represent total claims paid by the particular companies involved for the period October, 1978 through September, 1979.

EXHIBIT 25

THE COMMONWEALTH OF MASSACHUSETTS

GENERAL COURT

JOINT COMMITTEE ON INSURANCE

ADVANCES IN HEALTH INSURANCE IN MASSACHUSETTS

SEN. DANIEL J. FOLEY
SENATE CHAIRMAN

REP. RAYMOND M. LAFONTAINE
HOUSE CHAIRMAN

AUGUST 1974

[SEAL]

THE COMMONWEALTH OF MASSACHUSETTS
JOINT COMMITTEE ON INSURANCE
GENERAL COURT OF MASSACHUSETTS
STATE HOUSE, BOSTON

ANTHONY J. BURKE
RESEARCH DIRECTOR

DANIEL J. FOLEY
SENATE CHAIRMAN

RAYMOND M. LAFONTAINE
HOUSE CHAIRMAN

August 1974

The possibility of National Health Insurance has been increasing in recent years, with almost everyone expecting its implementation soon. However, our committee felt the need to act on some grave problem areas since years were passing without any policy emerging from Washington.

In 1973 two major pieces of health legislation were passed, providing in-patient and out-patient health coverage for mental illness and alcoholism. This year we passed a bill to provide for accident and sickness policies to cover newborn infants from the moment of birth and for premature birth and birth defects.

As a result of the passage of these measures, we have received many requests for copies of our laws with background data. We felt that by compiling the information we had, it could greatly assist other states who are considering these aspects of health insurance.

We hope you will find this material useful.

Sincerely,

/s/ Daniel J. Foley
DANIEL J. FOLEY
State Chairman

/s/ Raymond M. LaFontaine
RAYMOND M. LAFONTAINE
House Chairman

MEMBERS OF THE JOINT COMMITTEE ON INSURANCE

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SENATE CHAIRMAN

REPRESENTATIVE RAYMOND M. LaFONTAINE,
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PART ONE

MENTAL HEALTH INSURANCE

MENTAL HEALTH INSURANCE: WHO NEEDS IT?

There is a lingering myth that workers enjoy better health than other groups of population, or as put by Michael Harrington in *The Other America* that ". . . As far as emotional disturbance and mental disease go, the poor are noble savages and the rich are the prime victims of tension and conflict." If this were indeed true, a discussion of broadening insurance coverage as provided in Chapter 1174 of the Acts of 1973, for mental illness would have only limited relevance. There would be a thin market for this benefit. The truth is almost the exact opposite. Harrington cites the Yale studies by Hollinghead and Redlich which showed that the poor of New Haven had three times the rate of psychiatric illness as the other classes; and that the organized worker had a higher rate of mental illness than the rich and the executive professional classes.

The UAW reports that their studies of the needs of their members and families corroborate the findings of the Yale group and other investigators. Those needing mental health insurance the most, the workers, have the least ability to pay for mental health services.

Even more importantly though, there must be a new awareness among people that in today's pressured packed, rat raced society, no one group of the population is immune to mental sickness. Man is an imperfect being and at various points in life may be in need of care of one sort or another. The sooner this view point is accepted the sooner people will come to realize the need to be guarded against costly treatment for mental illness. The coverage in Chapter 1174 safeguards the people of Massachusetts, young and old, rich and poor, against the

burdensome costs of professional mental health services and care.

THE TREND TOWARDS COMMUNITY BASED CARE

Many are now aware that this state is engaged in an enormous revolution in the care of the mentally ill. For almost two centuries the mentally ill were dumped in massive human warehouses; out of sight and out of mind. As a number of studies have pointed out over the years, it was the working person who received the short end of the stick in this disgraceful abandonment of people whose only "crime" was that they had broken temporarily under the stresses of living. For the working persons and their families, there was no opportunity for private psychiatric treatment, or even community psychiatric care, which might have prevented a more serious illness. The first stop, and frequently the last stop for the worker, was a custodial state institution. The tragic price of this neglect can no longer be tolerated.

Institutional care, for many afflicted with mental illness is obsolete, and in many cases very damaging. In years before, the thinking was that by putting people in a totally new environment (such as an isolated mental hospital), you could save them from the things that made them sick. But as time progressed there was an increasing recognition that continuous hospitalization is frequently an anti-treatment device, making it all the more difficult for the mental patient to resume his/her duties in society. People began to realize that the state mental hospitals were polarizing the population into "sick" and "well". The mental hospitals were seen not as places for treatment but dumping grounds, that were too large and too impersonal.

In this new era, it has been demonstrated that the mental patient frequently does his/her best when he/she is vertically moving about, engaging in group activities,

working in industrial therapy and gradually re-adjusting to his/her real environment. Out-patient care given at a local community mental health center, in many cases, enables the mentally ill to receive adequate treatment without costly institutionalization. But since out-patient care is presently insuring only 1% of the people of this commonwealth, community mental health centers must be publicly supported, costing Massachusetts taxpayers millions of dollars annually. By making mental health coverage mandatory, Massachusetts can continue the thrust toward community based care. This will not only increase the availability for treatment in privately run mental health centers but save the taxpayers money as well.

MENTAL ILLNESS IS INSURABLE AT A REASONABLE COST

There is a widespread belief that mental health insurance plans such as Chapter 1174, cause premium rates to skyrocket. This belief though, is false, as facts show.

Massachusetts Blue Cross is covering mental illness at an annual cost of $9.00 for individuals and $17.00 for a family. This cost is less than 2% of total Blue Cross coverage which is now about $700.00 per year. This coverage is available in a ambulatory plan, but is restricted to large groups who carry master medical insurance.

The Health Insurance Plan of Greater New York has established monthly premiums for mental health services of $.90 for an individual, $1.80 for a family of two, and $2.70 for family of three or more. This averages about $7.50 per person per year when the distribution of family size is considered.[1]

Six million federal employees are covered for mental health services on an 80%, $100.00 deductible basis, with an overall maximum of $50,000.

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[1] Fink, R. "Financing Out-Patient Mental Health Care Through Psychiatric Insurance," Mental Hygiene, April, 1971 Vol. 55 No. 2.

The United Auto Workers health insurance plan which covers three million people and the Kaiser-Permanente Plan on the West Coast, with over one million subscribers, have coverage similar to that in Chapter 1174.

If mental illness is uninsurable, why are so many workers now covered? The reply may be that mental illness is insurable at a reasonable cost only when included in a large group policy. It is therefore felt rates for non-group subscribers would become exorbitant thus making any non-group health insurance policy offered in this state out of the reaches of the non-group consumer who is often on a limited or fixed income and in many cases barely able to afford any coverage. Massachusetts Blue Cross states that the "rate increase for the majority of non-group subscribers in the Commonwealth of approximately $1.15 per month for an individual and $1.70 per month for a family membership. Other non-group contract holders would have an increase in rates varying as to the type of contract held." [2] This increased premium is not much more than the amount now paid by many groups.

Yet in order for the cost to be reasonable, insurance for mental illness must be made a mandatory feature on all policies sold in the state. Otherwise this type of coverage would be extremely expensive to small group subscribers and especially burdensome to non-group subscribers. An optional offer to cover mental illness is contrary to the most basic principle of insurance—that of "risk sharing".

MENTAL HEALTH INSURANCE IS NOT ABUSED

The major worry of the insurance industry with regard to mental health insurance is that wider coverage for mental illness will lead to tremendous overutilization

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[2] Memorandum to Representative Raymond LaFontaine, June 19, 1973, from Massachusetts Blue Cross.

of services. The industry boasts that it is persuaded by cold facts but actually seems governed by hysterical fears. In other words, we are a nation of hypochondriacs—people who use every device to catch schizophrenia so that they can milk the insurance companies.

What are the actual facts? In reality, practically every study of mental health benefits has pointed to underutilization—people don't enjoy being institutionalized, or going to psychiatrists and being treated for mental illness.[3]

The Health Insurance Plan of Greater New York analyzed 60,000 subscribers in the Jamaica Medical Group. The subscribers were provided out-patient and in-patient psychiatric treatments—with no upper limit to the number of services and no cost to the patient.

Over a three year period, the annual utilization for psychiatric consultation was 11.4 per 1,000 or 1.1%. For psychiatric consultation with at least one visit, the rate was 8.3 per 1,000 or .8% During the period 949 patients were accepted for treatment and 16,264 Mental Health services were provided. Of these services, 88% were individual services to patients alone, or to patients with members of their families, 11% were group therapy services, and 1% were psychological testing.

Group Health Insurance of New York City offered out-patient psychiatric coverage to 76,000 subscribers over a 36 month period. Of the relatively small 1% of the sample who availed themselves to the coverage, one half admitted that they had psychiatric symptoms for two years or more, yet they were reluctant to seek treatment. Furthermore, only 1% of those who sought treatment were rejected on grounds of "no need for treatment."

Retail Clerks Local 770, in Los Angeles offers to its more than 50,000 members 111 days a year of in-hospital

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[3] Fink, R. "Financing Out-Patient Mental Health Care through Psychiatric Insurance" *Mental Hygiene* April, 1967, Vol. 55, No. 2.

psychiatric care, plus unlimited out-patient services, including group therapy and a broad range of services for the children of workers. From the inception of this plan in 1959, the problem has been underutilization by the membership. During the first three years of operation, only about 1% of those covered sought treatment; an aggressive campaign by the medical staff has lifted the rate to about 3% in recent years.[4]

This data indicates that those insured for mental illness do not abuse the privilege.

MENTAL HEALTH INSURANCE DECREASES NON-PSYCHIATRIC CARE

A study[5] by the Group Health Association (GHA) in Washington, D.C., which covers Federal Employees, demonstrated that the provision of mental health services reduced substantially the amount of non-psychiatric care provided to a given population.

Two-hundred-fifty-six patients, who were members of GHA for twelve months prior to and after the study, were referred to out-patient psychiatric treatment. After referral, there was a significant reduction in their utilization of physicians services, laboratory and X-Ray procedures by that group. Reduction in overall utilization was 30%. Therefore, mental health insurance reduces substantially the amount of non-psychiatric medical care, and even more important, it results in provision of medical care *more appropriate* to the illness of the patients.

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[4] Gorman, M. "Community Psychiatric Care: A New Era," National Conference of Mental Health, Jan. 26, 1968.

[5] Goldberg, I. Trantz, G. Locke, B. "Effect of Short Term Out-Patient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program" *Medical Care* Sept.-Oct. 1970, Vol. 8, No.5.

Another study [6] compared the utilization of 152 patients who initially received mental health services from the Kaiser Foundation Health Plan, with a carefully matched control group of an equal number who were high medical care utilizers but who had not received psychiatric services. Among the control group there was no significant difference in medical care utilization for the first three years, but in the fourth and fifth year the control group increased their medical care utilization significantly; 27.2% in the fourth year and 13.28% in the fifth year. But for the group who had received psychiatric care, there was a decrease in non-psychiatric medical care utilization of 21.4% the first year, 39.2% the second year, 48.2% the third year, 52.3% the fourth year, and 62.5% the fifth year.

Insurance companies are now paying for medical services that evidently could have been treated at an earlier stage, without hospitalization and less cost if psychiatric care was provided. When no mental illness insurance is provided many patients waited until their mental problems affected them physically before treatment was sought out.

SUMMARY

There is no justification for excluding benefits for mental health services in all health insurance policies sold in this commonwealth.

1. Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today.

2. It has been demonstrated that mental health insurance is insurable at a reasonable cost for groups. Blue Cross indicates only a slight increase for non-group sub-

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[6] Cummings, N. Follette, W.: "Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting" *Medical Care* Jan.-Feb. 1970, Vol. 5, No. 1.

scribers over what group members now pay for mental health benefits.

3. There is a growing trend in this state towards community mental health care. No longer will institutionalization be the answer for the majority of the mentally ill.

Instead, out-patient treatment delivered close to home at early stages will be tomorrow's answer. In order to enlarge this system and make it available to millions of Massachusetts residents mental health insurance must be mandatory on our health insurance policies sold in this commonwealth.

4. Studies show that people who have mental health insurance do not abuse it, even with no limit to the number of services and with no co-payment. Mental health benefits are moderately utilized.

5. Mental health insurance significantly reduces the amount of non-psychiatric medical care to a given population. This indicates that people who do not have mental health insurance either wait until their illness physically affects them, or are being treated in a manner not appropriate to the illness.

6. There is a great potential for increased revenue to the commonwealth, because of 3rd party payments from insurance companies. Connecticut in their first year of their mental health insurance bill realized an increase in third party payments in the amount of 1.5 million dollars—an increase of approximately sixty percent. If Massachusetts had proportionately the same success with third party payments as Connectiut, a sixty percent increase could mean an additional six million dollars in revenue. Although this increase is a very optimistic one, the potential for increased revenue is there.

7. The most humanitarian reason for mandatory mental health insurance against the mentally ill is ended.

It means that the state, by making mental health insurance mandatory on all policies, officially recognizes that mental illness is a health problem that all must be protected against. No longer will the mentally ill be forced to go to a public institution instead of a local private institution because they could not get mental health insurance.

THE BLUE CROSS EXPERIENCE WITH MENTAL HEALTH INSURANCE

The Blue Cross system, which provides prepayment coverage for over 66 million members, provides some coverage for mental illness for at least 80 per cent of this number. The benefits vary by contract within Blue Cross area and range from a minimum coverage to one hundred per cent payments.

Prior to 1954 coverage for nervous and mental diagnoses was limited to ten days of inpatient care in an acute general hospital during the lifetime of a member. This limited coverage was not intended to be used for treatment of the patient. It was to provide benefits while a patient's illness was being diagnosed as a mental condition. Then, because in those days general hospitals did not, as a rule, treat mental illness, the patient was discharged, often to be admitted to a mental hospital.

In 1954 the new Prolonged Illness Certificate, a supplement to basic Blue Cross and Blue Shield, provided additional inpatient benefits up to $300 in an acute general hospital over and above the ten days in the basic certificate, and the 1954 Prolonged Illness Certificate included benefits for electric or insulin shock therapy for a bed patient, in the out-patient department, or in the doctor's office.

In 1956 Prolonged Illness Certificate holders' acute hospital benefits for mental illness were expanded to 120 days and an additional 60 days were provided in a mental

hospital. Out-of-hospital care was still limited to electric or insulin shock therapy.

Blue Cross's response to the demand for major medical coverage was introduced in 1956 through the known Master Medical contract. This contract provided for a dramatic liberalization of benefits for mental admissions in that it removed the restriction on the number of days. In other words, an unlimited number of days are provided although there is an overall maximum in terms of dollars. The overall maximum is usually $15,000. The Master Medical also provides for 60 days in a mental hospital with out-of-hospital benefits limited to electric or insulin shock therapy.

In February of 1968 a further expansion of benefits under the Master Medical contract was made by making available benefits for charges in connection with psychiatric services, other than electric shock treatments, in the out-patient department of Blue Cross participating hospitals up to a maximum amount of $300 in any calendar year. At the same time in-patient benefits for all basic group and non-group contracts were raised to 30 days a calendar year in an acute general hospital.

It is obvious that to date there has been an expansion of benefits under Blue Cross, but that the emphasis has been on in-patient care. Today Blue Cross is responsible for the administration of a number of programs involving more liberal coverage for mental illness.

The Program Available

1. Psychiatric coverage for United Auto Workers:—the program provides 45 days in-hospital care, including physician; other than in-patient care ($400 maximum)—(a) all hospitals-professional and other ancillary services available to ambulatory patients, (b) visits for therapy, (c) family counseling services, (d) group psychotherapy, and (e) psychological testing by psychologist when pre-

scribed by a psychiatrist. All of the above out-of-hospital care is available in the doctor's office, OPD facility, or day or night care facilities.

2. Psychiatric coverage for those in the Federal Employees program:—(a) 80% of the following physicians' services—initial evaluation, subsequent psychotherapy, and psychological testing; (b) 80% of prescription drugs; (c) 80% of included services in the OPD, clinic, and day/night care unit, including nurse and social worker services; (d) there is a deductible of $100 and 20% copay; the overall maximum is $50,000.

3. Psychiatric coverage under Medicare:—(a) hospital services—inpatient—90 days per spell of illness, lifetime maximum of 190 days, $40 patient deductible per admission, $10 patient copay 61st to 90th day; OPD diagnostic services—necessary diagnostic services, $50 annual patient deductible, 20% coinsurance on balance; and OPD therapeutic services; (b) physician's services as in-patient are all covered with a $50 patient deductible (OPD deductible is credited) and 20% coinsurance on balance; ambulatory services are (i) all physician services (ii) annual maximum payment based on the following basis—reasonable charges up to $500 annual maximum.

Although not provided through Blue Cross, except for the Division of the Blind, to complete the picture the following describes the psychiatric coverage under Medicaid:—(a) in-patient hospital services—unlimited days, no deductibles, copays, or coinsurance; no coverage in a state institution; (b) out-patient clinics—unlimited; (c) physicians' services—all necessary psychiatric services by a physician in the hospital (not a state institution), office, home, skilled nursing home, or elsewhere; (d) other services—prescribed drugs for use outside of the hospitals. Although there are no deductibles, copay, or coinsurance factors as such, there is a factor of monthly excess income, that amount that is in excess of the

monthly income requirements set by public welfare which has to be applied toward any and all monthly medical expenses. Blue Cross and Blue Shield, or any other insurance, would have to be applied initially. In other words, any amount payable under Medicaid must be reduced by the amount of the monthly excess income applicable to the expenses incurred in the same month.

In 1967, the Program Development staff at Blue Cross began developing a program to provide comprehensive ambulatory psychiatric benefits. They have consulted with the Massachusetts Mental Health Association, with representatives of the New England Branch of the American Psychiatric Association, with the Massachusetts Psychological Association, with officials of the State Department of Mental Hygiene, and of course with the management staff at Blue Cross and Blue Shield.

As a result, Blue Cross now offers an ambulatory psychiatric benefit plan to all Master Medical groups of 75 or more employees.

Specifically, the plan provides up to $700 in physician's services in a 24-month period. Because the plan pays physician's usual and customary charges, it provides full payment for physician's services, including:

1. the initial psychiatric evaluation
2. private and group psychotherapy
3. check-up visits
4. family interviews and counseling

In addition, the plan will provide up to another $700 in a 24-month period for other than physician's services—such as

1. psychological testing
2. services of a community mental health center, of a day or night care center, of a clinic, and services in a

hospital out-patient department. Payments to these institutions will include payment for the services of their psychiatric nurses and psychiatric social workers. Payments for these other than physician's services will be according to a liberal fee schedule.

The absence of a drug benefit under this program was intentional since drug coverage will be made available under the existing Master Medical contracts.

The monthly premium for this program is $.90 for an individual and $1.40 for a family.

In the development of this program Blue Cross has included benefits for all acceptable forms of evaluation and treatment; they have made benefits available in all acceptable and recognized facilities in which a physician has responsibility for a patient; they have removed the financial deterrent to seeking immediate care by offering first dollar coverage; they have provided for continuity of care from in-patient to out-patient, from out-patient to day care, from treatment in one setting to another, without penalties in the form of co-riders or deductibles, so that the patient's condition, and not the structure of his insurance benefits will dictate the course of the treatment.

The type of coverage provided by Blue Cross and the cost of the mental health rider effectively ruins the industry argument that this insurance is not financially feasible.

The committee felth that although Blue Cross had made good innovations over the years that mental health insurance must be made a mandatory feature on every plan. Thus, it was decided that one standardized plan for all health insurers would be drawn up.

ANALYSIS OF CHAPTER 1174

On January 1, 1972, Connecticut enacted Public Act 238 *, thus becoming the first state in the nation to insure its citizens against mental illness. The Connecticut act applies to group policies only, and provides for thirty days coverage for in-patient care.

In the 1973 legislative session, the Joint Committee on Insurance had before it a bill quite similar to the Connecticut act. The Committee favored the legislation and ordered a new study of the Connecticut act in order that loopholes might be closed.

The staff contacted many governmental and industry spokesmen in Connecticut, and found that Public Act 238 had been less than adequate. Generally it was suggested that any proposed legislation providing for mental illness insurance should contain the following provisions:

1. Coverage be provided under any medical benfits contract issued by any insurance company, hospital service corporation, medical service corporation, or employees health and welfare fund. They found difficulty in Public Act 238 which covers only insurance benefits sold on a group basis.
2. Mental or nervous conditions be any psychiatric disorders as included in the standard nomenclature of the American Psychiatric Association.
3. Benefits be included in any *existing* policy or contract as well as all *new* policies or contracts *issued* and *delivered* to a person *residing* or *employed* in your state.
4. That benefits be paid to any state facility, hospital, or institution which is accredited as a hospital or medical facility.

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* See Appendix A.

It can be seen that Chapter 1174 of the Acts of 1973 * reflects these changes and more. The Committee redrafted the legislation which contains the following main features:

1. Any group individual contract is to contain the mental illness provisions as well as Blue Cross-Blue Shield and Employees Health and Welfare Funds.
2. It applies to any policy which is issued or subsequently renewed.
3. It applies to all residents in the state, regardless of where the policy is purchased.
4. It is to cover any nervous or mental condition as described in the standard nomenclature of the American Psychiatric Association which are equal to the following minimum requirements:

(a) In the case of benefits based upon confinement as an in-patient in a mental hospital under the direction and supervision of the Department of Mental Health, or in a private mental hospital licensed by the Department of Mental Health, the period of confiement for which benefits shall be payable shall be at least sixty days of any calendar year.

(b) In the case of benefits based upon confinement as an in-patient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

(c) In the case of out-patient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, service furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital, (3) or subject to the approval of the Department of Mental Health clinic or day care center which furnishes mental health

services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or a psychologist licensed under the provisions of Chapter 112.

5. The coverage is optional until January 1, 1974, wheneupon [*sic*] it will be mandatory on all health insurance policies.

The Committee believes that this legislation is the best in the country and hopes that other states will adopt this model.

IMPLICATIONS FOR STATE REVENUE GAIN

The pioneering experience of the state of Connecticut in enacting a law similar to Chapter 1174 is instructive from the point of view of revenue gain for the state.

It has been suggested that insurance coverage for psychiatric illness might lead potential patients away from state operated facilities to private facilities or psychiatrists. The implication is that the publicly-operated programs could not "stand the competition" and would lose "customers," with the result that there would be a loss of revenue to the state. The Connecticut experience indicates that this is not so. *In Connecticut since 1971 there has been an increase in revenue to the state from private health insurance payments to state hospitals and state operated clinics.* The figures on Connecticut substantiate this statement.

In FY 1971 the state of Connecticut received the following amount from private health insurance companies (Blue Cross and commercial carriers) for the in-patient care of mental illness: [7]

$2.5 million

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[7] Figures are reported by Charles Rourke, Supervisor, Institutional Accounts, Division of Central Collection, State of Connecticut, (Telephone interview, July 17, 1973).

In FY 1972 the state of Connecticut received from Blue Cross and other insurers the following amount:

$4 million

Thus, the state received additional revenue from private insurers after passage of the Connecticut act of approximately 1.5 million dollars. This figure for additional revenue is particularly interesting in the light of the fact that in 1972 Connecticut spent approximately the amount to operate its institutions as Massachusetts $84 million. In 1972 Massachusetts spent $82 million. It is not unrealistic to expect that our state can realize a comparable gain in revenue through passage of a psychiatric insurance bill such as Chapter 1174.

With regard to out-patient care, it is also clear that psychiatric insurance coverage does not result in declining revenue to state operated clinics. *Connecticut reports an increase in revenues to its state operated clinics and day care centers from private insurers between 1971 and 1972.* In 1971 Connecticut clinics and day care centers received approximately $547,000 in fees. In 1972 these clinics brought $645,000 in revenue to the state.

PAYMENTS TO STATE OPERATED OUT-PATIENT CLINICS

This year there will be approximately 360,000 patient visits to mental health clinics operated by the state of Massachusetts (located in community mental health centers or staffed by state hospital personnel).[8]

At the present time, these clinics are able to collect insurance payments from only about 2% of the patient who use them. The business managers of these clinics

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[8] Based on figures for April, 1973. There were 29,910 visits to state operated mental health clinics in April, 1973. When multiplied by 12, the annual number of visits is 358,920. (Massachusetts Department of Mental Health, *Monthly Statistical Report,* April 1973).

estimate that 35% of the patients who use their clinics have some form of health insurance which covers hospitalization but not out-patient care. This situation would change, since Chapter 1174 requires *out-patient* as well as in-patient coverage. If the health insurance policies of those people who use these clinics were to include coverage for out-patient care (as required under Chapter 1174), these clinics would be able to collect close to a million dollars in third party payments ($921,014).[9]

The following example illustrates the potential for new revenue to the state through passage of Chapter 1174:

In FY 1972 the out-patient clinics at the Corrigan Mental Health Center in Fall River and the Solomon Mental Health Center in Lowell collected the following amounts through fees:[10]

Corrigan Mental Health Center (Fall River)	$ 4,024
Solomon Mental Health Center (Lowell)	11,954
Total	$15,978

As indicated, approximately 35% of the patients who use these clinics have some form of health insurance. If those people with health insurance who now use the clinics had policies which included out-patient care (as required under Chapter 1174) the two mental health centers would have been able to collect at least the following amounts from private insurers:[11]

Corrigan Mental Health Center (Fall River)	$ 34,327
Solomon Mental Health Center (Lowell)	89,362
Total	$123,689

This figure represents almost eight times more revenue for the state than the clinics have been able to collect in the past through fees from patients.

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[9] Calculations are on the basis of current rates set by the Rate Setting Commission (see attached rate schedule).

[10] Figures from Massachusetts Department of Mental Health Financial Reports, 1972.

[11] Calculated on the basis of 11,566 out-patient visits to Corrigan and 16,058 to Solomon in 1972, using current per diem rates and assuming approximately 35% coverage through health insurance.

PART TWO

ALCOHOLISM INSURANCE

INTRODUCTION

The Joint Committee on Insurance saw the need to assure financing for hospital care and other health services for treatment of the disease* of alcoholism. The current ambivalent approach to the alcoholic has encouraged hospitalization under an inappropriate diagnosis; has failed to stimulate the development of proper medical and health care for the alcoholic; and has contributed to insurance costs due to late diagnosis.

PROBLEM STATEMENT

Since alcoholism is a complex disease with medical, psychiatric, psychological, social and vocational disorders, the treatment has to correspond to the complexity of the patient's condition. The total treatment must be multi-disciplinary in order to adequately deal with many disorders, either causative or sequential. It must offer acute care (detoxification), diagnostic evaluation, specialized treatment, ongoing aftercare, and where needed vocational rehabilitation and Alcoholics Anonymous.

Hospital insurance coverage for admission to a general or specialized hospital and participation in hospital aftercare programs are among those services often "unavailable" to alcoholics. Continuity of care, between inpatient and out-patient services so necessary to the successful rehabilitation of the alcoholic, is not covered by insurance and therefore is too often lacking.

It is apparent that the alcoholic needs a specific and comprehensive treatment program to enable him to regain total health. All phases of this treatment for the

* See Appendix C.

disease of alcoholism should be included in insurance coverage. It should be emphasized that the treatment program carried out in the general hospital setting is usually for late complications and is not directed to a comprehensive program for the alcoholic.

EXISTING GAPS

In its discussion the committee recognized that the development of adequate financing of care for the disease alcoholism required the development of broad and intensive educational programs. Current lack of understanding of this disease and requirements for its treatment, on the part of employers, insurance companies, and many others is of serious concern, for it does inhibit prompt development or broad insurance coverage and permits continued wasteful and ineffective expenditures on the part of the insurance companies and others.

Proposed grant-in-aid legislation, or private, or local community funds may provide for the initiation of specialized programs for alcoholics. To insure the continuation and stable operation of these programs, while providing for their growth, requires the development of stable financing mechanisms. Provisions for such stability in financing the treatment for alcoholism can be provided by extending the same basic coverage that is given to treatment of other diseases. The bulk of the alcoholic patient population is adequately insured and treated for other illnesses caused by alcoholism; therefore, it seems logical that the same insurance should cover treatment for this disease.

The committee is aware of the urgent need for additional treatment facilities and manpower. It is obvious that the further development of facilities and the support of trained manpower can be expected to follow the development of adequate insurance mechanisms.

Theoretically an insurance company will write any kind of coverage requested by the purchaser including

coverage for treatment of alcoholism. In reality many policies are written either with the exclusion of alcoholism or with reduced benefits. The reasons for this are included among the following issues: (1) lack of willingness on the part of the purchaser to pay the additional costs required for the extended benefits; or (2) because of a reluctance on the part of the insurance company to recommend coverage fearing that the excessive costs may cause the contract to be less competitive. When coverage is provided it is often limited by the following: (1) coverage only in a *general hospital* with a limited number of days allowed which may vary from 15 to 30 days and may limit this to only once a year; (2) coverage limited under the *sanitoria* clause providing for a predetermined per diem rate and a designated number of days; or (3) coverage limited under the *mental and nervous disorder* clause limiting not only the number of days for hospitalization but also the percent of cost coverage.

STANDARDS FOR TREATMENT

The committee feels that alcoholism should not be considered exclusively as a mental disorder ignoring the physiological ramifications but that especially with alcoholism the maintenance of total health is the prime concern. Insurance benefits should provide complete coverage on an in-patient and out-patient basis whether in a general or special hospital. Specialized treatment facilities properly licensed and accredited where a patient is diagnosed and treated by a multi-disciplinary team functioning under the jurisdiction of a physician, should be acceptable for full insurance coverage.

Guidelines for a total treatment program should include medical evaluation, treatment, and supervision for the acute toxic metabolic phase of the illness, commonly referred to as detoxification and which is preliminary to comprehensive diagnostic and treatment program for the alcoholic and his family.

Such a program may be conducted in a general or special hospital in its entirety or in the form of a program which they conduct cooperatively. It will require (a) hospital licensure; (b) a staffing pattern adequate to meet the objectives of a comprehensive alcoholism treatment program; and (c) an organized medical staff with provision for 24 hour nursing care.

A comprehensive diagnostic treatment program should include evaluation, didactic lectures, as well as a group and individual psychotherapy program under ongoing medical supervision. To provide such a program a multidisciplinary staff is required including the utilization of recovered alcoholic counselors.

RECOMMENDATIONS OF THE COMMITTEE

1. That alcoholism be covered to the extent of the basic policy in every health insurance plan operable in Massachusetts.
2. That insurance coverage should be flexible to permit individualized treatment of the alcoholic as determined by the hospital staff, and to include both in-patient and out-patient care.
3. That insurance carriers be urged and encouraged to conduct educational programs for their staffs so as to develop better understanding of alcoholism.
4. That companies—management and unions—recognize their role and responsibilities for creating a better understanding of alcoholism.
5. That management and labor accept their responsibilities to work together with their health insurance carrier to provide comprehensive health services for the alcoholic employee.
6. That health and compensation insurance carriers inaugurate insurance alcoholism programs simi-

lar to safety engineering programs designed for early referral and treatment of alcoholism in business and industry with the consequent reduction of economic losses due to alcoholism.

7. That the committee urges that efforts be made to have health insurance carriers and providers of health services work together to develop sound statistical and fiscal data with respect to the disease of alcoholism to facilitate sound program and fiscal planning for the future.

ANALYSIS OF CHAPTER 1221

In 1971 the state of Wisconsin passed Assembly Bill 1348 * which provided for the coverage of alcoholism in all health insurance policies, effective in September 1972.

When the Joint Committee on Insurance decided to pursue this type of legislation in 1973 the Wisconsin legislation was discarded as being too vague and full of loopholes. Therefore, the committee staff decided to use the wording developed in the Mental Health Act, Chapter 1174. For all intensive purposes, the analysis of the two acts is the same, except for the benefits which are to be equal to at least the following: **

(a) In the case of benefits based upon confinement as an in-patient in an accredited or licensed hospital or in any other public or private facility thereof providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Department of Public Health for those services, such benefits shall be at least thirty days in any calendar year.

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* See Appendix D.

** See Appendix E.

(b) In the case of out-patient benefits these shall cover, to the extent of five-hundred dollars over a twelve-month period, services furnished by (1) an accredited or licensed hospital, or by (2) any public or private facility or portion thereof providing services especially for the rehabilitation of intoxicated persons or alcoholic and which is licensed by the Department of Public Health for those purposes.

(c) The provisions of the legislation are optional to the policyholder until January 1, 1976, when they shall become mandatory.

PART THREE

NEWBORN HEALTH INSURANCE

INTRODUCTION

The Newborn Health Insurance Act of 1974, Chapter 785, provides for immediate insurance coverage to new born children on all family insurance programs offered in the Commonwealth. At the present time many major medical insurance policies do not provide coverage for immediate care of new born children. There are often exclusions from 10 to 30 days after birth and many policies exclude congenital defects from coverage forever.

This legislation is a necessity because the cost of medical care for new born children with congenital medical problems has often resulted in bankruptcy for young families. Many young parents are often unaware that their medical policy holds an exclusion in coverage for the early days of a child's life. On the other hand, incidence of these cases is actually low enough in comparison with the general cost of health insurance that it would not greatly affect cost of commercial insurance policies. The average cost of the expanded coverage has been only $5.00 per year in the seven states which have already adopted the legislation.

In Massachusetts, out of 80,000 births, 700 new born infants were transferred to special care nurseries for urgent medical care. During the period 1972-1973 at the Boston Hospital for Women, one to three percent of newborns required care for major congenital abnormalities. Many of these infants were without insurance coverage under present policies.

Blue Cross, which provides for about 60 percent of the health care insurance for the state has now adopted this provision. In general, the need remains among the other 40 percent of insurance providers.

When this provision was added to existing coverage in California by Blue Cross in October 1973, the cost to date has turned out so small that no additional premium at all was required for the program.

Mandatory legislation would clearly not place difficult financial burden upon insurance carriers in terms of marketing such a policy nor upon the consumer in purchasing such a policy.

ANALYSIS OF CHAPTER 785

The language of Chapter 785* providing for newborn health insurance is drawn from the two proceeding health insurance acts. The Committee decided that for the purposes of uniformity in the General Laws and to protect against loopholes in the "Model Newborn Insurance Program", an industry favored bill, the language evolved in the last session would be superior.

The Committee also favored a feature in the bill that would protect the insurance consumer in the event of a failure to notify the insurance carrier of a new dependent. The bill states that in the event a policyholder fails to notify the company, a submission of a claim will serve as notification.

Newborn children in Massachusetts from January 1, 1975 onward will now be covered at the moment of birth for ordinary accident and sickness benefits as well as congenital birth abnormalities and premature birth.

No longer will the threat of financial disaster result from complications at birth.

PART FOUR

APPENDIX

APPENDIX A

Substitute House Bill No. 5076

Public Act No. 238

AN ACT CONCERNING PROVISION IN HEALTH INSURANCE POLICIES, HOSPITAL SERVICE CONTRACTS AND MEDICAL SERVICE CONTRACTS FOR BENEFITS AGAINST MENTAL ILLNESS COSTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Notwithstanding any provision to the contrary in the general statutes, no medical benefits contract on a group basis, whether issued by an insurance company, a hospital service corporation or a medical service corporation shall be sold in this state unless persons covered under such contract will be eligible for benefits for expense arising from mental or nervous conditions which are at least equal to the following minimum requirements: (a) In the case of benefits based upon confinement as an in-patient in a hospital, the period of confinement for which benefits shall be payable shall be at least thirty days in any calendar year. (b) In the case of major medical expense coverage, benefits, after the applicable deductible, shall be at a fifty per cent rate for covered expenses incurred by the insured while other than an in-patient in a hospital, and benefits shall be available for such expenses during any calendar year up to a maximum of five hundred dollars.

Section 2. This act shall take effect January 1, 1972.

Certified as correct by

_____

Legislative Commissioner

_____

Clerk of the Senate

_____

Clerk of the House

Approved _____, 1971

_____

Governor

APPENDIX C

I. *STATEMENTS ON ALCOHOLISM:*

House of Delegates, American Medical Association, 1956: "Alcoholic symptomatology and complications which occur in many personality disorders came within the scope of medical practice. Acute alcoholic intoxication can be and often is a medical emergency."

American Hospital Association, 1967: "Alcoholism is a serious health problem. It falls within the scope of medical practice and it is often a medical emergency. The alcoholic should not be denied the advantage of a thorough study of the cause or causes of his condition and should not be denied the advantage of the best possible management of his case."

American Psychiatric Association, 1965: "All prepayment plans for defraying the cost of medical care through insurance should cover the person presenting symptoms of alcohol problems who seeks treatment in medical settings on the same basis as for other illnesses."

II. *DEFINITION:*

ALCOHOLISM IS AN ILLNESS CHARACTERIZED BY PREOCCUPATION WITH ALCOHOL AND LOSS OF CONTROL OVER ITS CONSUMPTION SUCH AS TO LEAD USUALLY TO INTOXICATION IF DRINKING IS BEGUN; BY CHRONICITY; BY PROGRESSION; AND BY TENDENCY TOWARD RELAPSE. IT IS TYPICALLY ASSOCIATED WITH PHYSICAL DISABILITY AND IMPAIRED EMOTIONAL, OCCUPATIONAL, AND/OR SOCIAL ADJUSTMENTS AS A DIRECT CONSEQUENCE OF PERSISTENT AND EXCESSIVE USE.

COMMONWEALTH OF MASSACHUSETTS
TRIAL COURT
SUPERIOR COURT DEPARTMENT

SUFFOLK, SS.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

—against—

THE TRAVELERS INSURANCE COMPANY

—and—

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Sept. 24, 1980]

STIPULATION

1. Metropolitan Life Insurance Company ("Metropolitan") has approximately 80 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976 and which provide medical expense coverage to approximately 40,400 Massachusetts employees. To the extent such data is available, Exhibit A hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

2. Metropolitan has approximately 28 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976 and which provide medical expense coverage to approximately 3,528 Massachusetts employees. To the extent such data is available, Exhibit B hereto provides, for

certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

3. Metropolitan has approximately 33 group insurance contracts in force which were issued within the Commonwealth of Massachusetts prior to January 1, 1976 and which provide medical expense coverage to approximately 8,600 Massachusetts employees. To the extent such data is available, Exhibit C hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

4. Metropolitan has approximately 28 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976 and which provide medical expense coverage to approximately 20,100 Massachusetts employees. To the extent such data is available, Exhibit D hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

5. The Travelers Insurance Company ("Travelers") has approximately 57 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976 and which provide medical expense coverage to approximately 14,000 Massachusetts employees. To the extent such data is available, Exhibit E hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

6. Travelers has approximately 27 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976 and which provide medical expense coverage to approximately 13,000 Massachusetts employees. To the extent

such data is available, Exhibit F hereto provides, for certain of those contracts, the approximate number of employees residing within and outside of the Commonwealth of Massachusetts.

7. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth of Massachusetts and which provide medical expense coverage to approximately 45,000 Massachusetts employees. Of these contracts, an estimated 60% to 70% were issued prior to January 1, 1976.

8. Virtually all of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). There are, however, a few such contracts issued to provide benefits for plans not subject to ERISA, such as church or government plans as defined in ERISA. With respect to all or virtually all Metropolitan policies, Metropolitan acts as the named fiduciary for the review of denied claims pursuant to ERISA. Exhibit G hereto is a copy of the standard ERISA conforming instrument entered into by Metropolitan and its policyholders.

9. Metropolitan has approximately 49 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976, or which were issued within the Commonwealth of Massachusetts before January 1, 1976 and for which Metropolitan reserved the unilateral right to non-renew the contract, and which provide the benefits specified in G.L. c. 175, § 47B. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth and which provide the benefits specified in G.L. c. 175, § 47B. As a matter of policy and voluntary decision, defendants and those policyholders have provided the benefits specified by G.L. c.

175, § 47B. This paragraph is without prejudice to defendants' rights to assert any claims of fact or law in this action.

10. Certain of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans which are the product of collective bargaining agreements negotiated subject to the National Labor Relations Act. Certain of these collective bargaining agreements prescribe the particular type and level of medical expense benefits to be afforded employees while others prescribe the level or amount of contributions to be afforded employees, and the particular group insurance contract implements the terms of the collective bargaining agreement.

11. The preponderance of insurance policies affected by G.L. c. 175, § 47B have been issued to employers. A substantial number of these employers engage in business operations in other states as well as in Massachusetts, and have employees who live and work in such other states as well as in Massachusetts.

12. The Commonwealth is not seeking to enforce that part of G.L. c. 175, § 47B purporting to affect employee health and welfare plans directly.

13. The subject of health benefits, including mental health benefits, is a mandatory subject to collective bargaining, as to which employers subject to the National Labor Relations Act have a duty to bargain.

14. More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce. This is also true with respect to Travelers.

More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce, excluding all transactions and ac-

tions which occur primarily and substantially within the Commonwealth. This is also true with respect to Travelers.

15. The Report of Joint Committee on Insurance dated August 1974, copies of which are in the possession of the parties, is authentic and may be accepted in evidence.

16. (a) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1940 through 1975:

> RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding on which last date and on each anniversary of which last date the Employer may renew this Policy for a further term of one year, provided (1) the number of Employees then insured hereunder for Personal Insurance is, in the case of Contributory Insurance, not less than seventy-five percent of the number of eligible Employees and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees, and provided, in either case, the number of Employees then insured hereunder for Personal Insurance is not less than fifty and (2) the number of Employees insured hereunder for Dependent Insurance is, in the case of Contributory Insurance, not less than seventy-five percent of the number of eligible Employees with Dependents and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees with Dependents. Such renewal is conditioned upon the payment of the premium then due as computed in the manner set forth in Section 16 hereof and based upon such premium rates as may then be determined by the Insurance Company. (Exhibit H hereto is a copy of Section 16 referred to above.)

(b) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1976 through 1978. Certain contracts issued in 1975 also contained this provision.

> RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company. (Exhibit I hereto is a copy of Section 6 referred to above.)
>
> The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a) if the number of Employees then insured for each type of insurance provided hereunder is less than 75%* of the number of Employees eligible for such insurance, or (b) if the number of Employees then insured hereunder is less than 50.*

* Although the standard is 50, the number may be greater in certain contracts.

(c) Metropolitan group insurance contracts issued in 1979 and thereafter generally do not include a provision labelled "Renewal Privilege". The following is Metropolitan's standard group contract "Discontinuance Of The Policy" provision generally included in group contracts issued in 1979 and thereafter:

> DISCONTINUANCE OF THE POLICY—Metropolitan will have the right to discontinue this Policy if less than *75%** of the eligible Employees are in-

* Change to 100% in the case of non-contributory insurance. Not less than 75% in the case of contributory insurance.

sured for each type of insurance. Metropolitan will also have such right if less than *50** Employees are insured. Such right may be exercised by Metropolitan only on the last day of the first Policy Period or on the day before any Premium Due Date which occurs after the last day of the first Policy Period. Notice, in writing, that this Policy is to be discontinued must be given to the Employer by Metropolitan. The notice must be given at least thirty-one days** prior to the date this Policy is to be discontinued.

(d) Certain large groups have non-standard provisions in their group insurance contracts.

(1) The following "Renewal Privilege" provision forms the basis for the type of provision generally used for these groups:

RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.

The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a) if the number of Employees then insured for each type of insurance provided hereunder is less than 75% of the number of Employees eligible for such insurance, or (b) by giving at least ninety days prior written notice to the Employer.

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* Although the standard is 50, the number may be greater in certain contracts.

** Although the standard is 31, the number may be changed to a longer period of up to 90 days in certain contracts.

(2) The following "Renewal Privilege" provision is an example of a provision presently contained in one such large group contract.

> RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding January 1, 1956, on which last date and on each anniversary of which last date the Employer may renew this Policy for a term of one year, except that the Insurance Company reserves the right to discontinue this Policy on December 31, 1960 or on the day preceding any subsequent renewal date by giving written notice to the Employer at least

17. With respect to virtually every one of the Metropolitan insurance contracts referred to in paragraphs 1 through 4 above, since January 1, 1976 the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

18. Exhibit J hereto is a standard form of group insurance policy presently used by Travelers. The marked portions (which relate to continuity and discontinuance of the policy and modifications of the policy, including premium rate changes) have been virtually unchanged for the past 30 years.

19. With respect to virtually every one of the Travelers insurance contracts referred to in paragraphs 5 and 6 above, since January 1, 1976 the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. This is also true with respect to a substantial number of the Travelers insurance contracts referred to in paragraph

7 above. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

20. Exhibits K and L hereto are copies of current model or sample provisions for major medical expense benefits, including mental health benefits, which are offered by Metropolitan and Travelers, respectively, to their policyholders. These provisions are used in the absence of policyholder requests for different provisions. A substantial number of times they are accepted by policyholders.

21. Certain of Metropolitan's and Travelers' insurance contracts have undergone changes in the areas of mental health, retirees or surgical benefits or in other related areas of benefits or eligibility. Examples of such changes in the areas of mental health, retirees and surgical benefits are attached hereto as Exhibits M (Metropolitan) and N (Travelers).

22. With respect to G.L. c. 175, § 47B ("Section 47B"), there is: (a) substantial compliance by Metropolitan and substantial noncompliance by Travelers with Section 47B(a); (b) substantial compliance by Metropolitan and Travelers with Section 47B(b); and (c) substantial noncompliance by Metropolitan and Travelers with Section 47B(c).

23. Defendants' exhibit reflecting the number of "Administrative Services Only" contracts issued by Metropolitan in recent years is authentic and may be admitted into evidence.

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COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT
DEPARTMENT OF THE TRIAL COURT

SUFFOLK, SS.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

v.

THE TRAVELERS INSURANCE COMPANY
METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Sept. 25, 1980]

STIPULATION

1. During the years 1976-1980, the Commonwealth of Massachusetts expended the following amounts for institutional mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980	
87.6	86.8	93.1	96.4	88.4	Million

2. During the years 1976-1980, the Commonwealth of Massachusetts expended the following amounts for community based mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980	
26.8	36.8	45.1	60.5	108.3	Million

These funds are distributed to public and private community mental health centers, and other community men-

tal health organizations, a substantial number of which derive a substantial portion of their revenue from third party insurance payments.

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Sept. 25, 1980

COMMONWEALTH OF MASSACHUSETTS
TRIAL COURT
SUPERIOR COURT DEPARTMENT

SUFFOLK, SS.

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS, PLAINTIFF

against

THE TRAVELERS INSURANCE COMPANY

and

METROPOLITAN LIFE INSURANCE COMPANY, DEFENDANTS

[Filed Sept. 25, 1980]

SUPPLEMENTAL STIPULATION

1. Virtually all claims submitted by or on behalf of Massachusetts residents pursuant to Metropolitan's group insurance contracts in force are received, reviewed, processed, and paid or denied outside of the Commonwealth of Massachusetts. In certain cases, Metropolitan policyholders with operations within the Commonwealth will be responsible for the actual transmission of claims from employees to Metropolitan.

2. With respect to certain of Travelers' group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts, claims submitted by or on behalf of Massachusetts residents pursuant to such contracts are received, reviewed, processed and paid or denied outside of the Commonwealth. With respect to certain other of Travelers' contracts in force which were

issued outside of the Commonwealth, including the contract issued to G.T.E., some claims are received, reviewed, processed and paid or denied within the Commonwealth and some claims are received, reviewed, processed and paid or denied outside the Commonwealth.

3. The policy clauses referred to in paragraph 16(a) and (b) of the initial Stipulation and the marked clauses referred to in paragraph 18 of that Stipulation are contained in many of defendants' group insurance contracts in force covering Massachusetts residents and issued prior to January 1, 1976. Under these clauses, a policyholder may exercise its right to non-renew or discontinue its contract even if claims paid and expenses incurred by the insurer exceeded premium payments made to the insurer. This may leave the insurer with a net loss under the contract which it would be unable to recover from the policyholder. Even if the policyholder does not nonrenew or discontinue the contract under those circumstances, the insurer will often be unable to recover the loss during the subsequent year.

4. There are approximately 82 community mental health centers and clients subject to reimbursement pursuant to G.L. c. 175, § 47B(c)(3).

5. The inpatient population of Massachusetts state mental hospitals has decreased from approximately 13,482 in 1969 to approximately 2,328 in 1980.

SUPREME COURT OF THE UNITED STATES

No. 84-325

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

Appeal from the Supreme Judicial Court
of Massachusetts

The statement of jurisdiction in this case having been submitted and considered by the Court, in this case probable jurisdiction is noted. This case is consolidated with case No. 84-356, *Travelers Insurance Company* v. *Commonwealth of Massachusetts*, and a total of one hour is allotted for oral argument.

October 29, 1984

SUPREME COURT OF THE UNITED STATES

No. 84-356

TRAVELERS INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

Appeal from the Supreme Judicial Court
of Massachusetts

The statement of jurisdiction in this case having been submitted and considered by the Court, in this case probable jurisdiction is noted. This case is consolidated with case No. 84-325, *Metropolitan Life Insurance Company* v. *Commonwealth of Massachusetts*, and a total of one hour is allotted for oral argument.

October 29, 1984